

Universidade NOVA de Lisboa

Faculdade de Ciências



Mental Health Care assessed based
On Structure, Process and Outcome
A Retrospective Cohort Study

Masters Dissertation
International Master in Mental Health Policy and
Services

Natasha Van Schalkwyk Pimenta de Oliveira

Supervisor: Professora Doutora Graça Cardoso

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Dedicated to João and Tiago,

*“Julle is my inspirasie,
dankie dat julle in my lewe
is”*

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ABSTRACT

Mental health disorders are common, universal, and associated with heavy personal, family, social and economic burden. Mental health services should be aimed at adequately addressing patients' and families' needs at clinical and social level.

The current study was carried out at a time of great transformation in the health and mental health systems in Portugal, in a Psychiatric Department developed taking in consideration the WHO principles.

The **objectives** included characterizing: 1) the Psychiatric Department's different units; 2) the patients admitted for the first time to the inpatient unit; 3) their use of community mental health services after discharge; and 4) assessing some of the department's quality indicators, with resource to Donabedian's Structure-Process-Outcome model.

Methodology: A retrospective cohort design was chosen. All the firstly admitted patients in the period between 2008 and 2010 were included in the study. Their clinical records and the hospital's database which registers all of the contacts the patients had with the mental health professionals during the study period, were reviewed to retrieve sociodemographic and clinical data and information on follow-up. The instruments used were the WHO International Classification of Mental Health Care (ICMHC) to characterize the department, the Initial Nurses' Assessment in Mental Health and Psychiatry (AIESMP) for patients' sociodemographic data, and the Verona Service Satisfaction Scale (VSSS) to assess patients' satisfaction with care received. Statistical analysis included descriptive, quantitative and qualitative analysis of the data.

Results: The Department's Functional units revealed high levels of articulation, and were consistent with patients' needs for psychiatric care and psychosocial rehabilitation. The 543 patients firstly admitted were mainly (56.9%) female, Caucasian (81.2%), diagnosed with mood disorders (66.3%), voluntarily admitted (59.7%), and with a mean age of 45.1 years. Female patients were significantly older, more frequently employed, married/cohabiting and had a higher prevalence of mood disorders when compared to males. Involuntary admission was more significant in males (54.7%). Dropout rates during follow-up (4.2%) and readmission rates (2.9%) in the fortnight following discharge were lower than standards in international literature. Overall patients' satisfaction with mental health care was positive.

Conclusions: The care delivered was effective, adapted and based on the patients' specific needs and problems. Continuity and comprehensiveness of care was

endorsed and maintained throughout the care process. This department may be considered an example of both humane and effective treatment, and a reference for future psychiatric care.

Key words: Psychiatric Services, Quality Assessment, Psychiatric Admissions, Patients Satisfaction, Assertive Community Treatment.

RESUMO

As doenças mentais são comuns, universais e associadas a uma significativa sobrecarga pessoal, familiar, social e económica. Os Serviços de Saúde Mental devem abordar de forma adequada as necessidades dos pacientes e familiares tanto ao nível clínico como também ao nível social.

O presente estudo foi realizado num período de grande transformação nos sistemas de saúde primário e de saúde mental em Portugal, num Departamento de Psiquiatria desenvolvido com base nos princípios da OMS.

Os **objectivos** incluem a caracterização: 1) das Unidades Funcionais do Departamento; 2) dos pacientes internados pela primeira vez no internamento de agudos; 3) da utilização dos serviços nas equipas comunitárias após a alta; e 4) da avaliação de alguns dos indicadores de qualidade do departamento, com recurso ao modelo de Donabedian sobre a articulação entre a Estrutura-Processo-Resultados.

Metodologia: Foi escolhido um estudo de coorte retrospectivo. Todos os pacientes internados pela primeira vez entre 2008 e 2010 foram incluídos no estudo. Os seus processos clínicos e a base de dados do hospital onde são registados todos os contactos que estes tiveram com os profissionais de saúde mental foram revistos de forma a obter dados sociodemográficos e clínicos, durante o período do estudo e após a alta. Os instrumentos utilizados foram o WHO-ICMHC (Classificação Internacional de Cuidados de Saúde Mental), para caracterizar o Departamento, o AIESMP (Avaliação Inicial de Enfermagem em Saúde Mental e Psiquiatria) para recolha dos dados sociodemográficos, e o VSSS (Escala de Satisfação com os Serviços de Verona) de forma a avaliar a satisfação dos pacientes em relação aos cuidados recebidos. A análise estatística incluiu a análise descritiva, quantitativa e qualitativa dos dados.

Resultados: As Unidades Funcionais do Departamento revelaram níveis elevados de articulação e consistência com as necessidades de cuidados psiquiátricos e reabilitação psicossocial dos pacientes. Os 543 pacientes admitidos pela primeira vez eram maioritariamente (56.9%) mulheres, caucasianas (81.2%), com diagnóstico de perturbações do humor (66.3%), internadas voluntariamente (59.7%), e uma idade média de 45.1 anos. Estas eram significativamente mais velhas, mais frequentemente empregadas, casadas/coabitar e tinham uma prevalência mais elevada de perturbações do humor, comparativamente aos homens. O internamento compulsivo

era mais significativo nos homens (54.7%). A taxa de abandono no pós-alta (4.2%) e a taxa de reinternamentos (2.9%) na quinzena após a alta revelaram-se inferiores aos padrões na literatura internacional. De forma global, a satisfação dos pacientes com os cuidados de saúde mental foi positiva.

Conclusões: Os cuidados prestados mostraram-se eficazes, adaptados e baseados nas necessidades e problemas específicos dos pacientes. A continuidade e a abrangência de cuidados foram difundidos e mantidos ao longo do processo de cuidados. Este Departamento pode ser considerado um exemplo de como proporcionar tratamento digno e eficiente, e uma referência para futuros serviços de psiquiatria.

Palavras-chave: Serviços de Psiquiatria, Avaliação de Qualidade, Admissões Psiquiátricas, Satisfação dos Pacientes, Tratamento Comunitário Assertivo.

RESUMEN

Las enfermedades mentales son comunes, universales y están asociadas a una significativa sobrecarga personal, familiar, social y económica. Los Servicios de Salud Mental deben abordar de forma adecuada las necesidades de pacientes y familiares tanto a nivel clínico como social.

El presente estudio fue realizado durante un período de profunda transformación de los sistemas de salud primaria y de salud mental en Portugal, en un Departamento de Siquiatría y fue desarrollado con base a las normas que establece la OMS.

Los **objetivos** de este trabajo incluyeron la caracterización de: 1) las Unidades Funcionales del Departamento; 2) Los pacientes ingresados por primera vez en la sala de agudos; 3) la utilización de los servicios en los equipos comunitarios después del alta; 4) la evaluación de algunos de los indicadores de calidad del departamento, según el modelo de Donabedian aplicado a la articulación entre la Estructura-Proceso-Resultados.

Metodología: El estudio escogido fue de cohorte retrospectivo. Con el propósito de obtener datos socio-demográficos y clínicos durante el período de estudio y después del alta fueron incluidos todos los pacientes con un primer ingreso entre 2008 y 2010 así como analizadas todas las historias clínicas y la base de datos del hospital donde son registrados los contactos que los pacientes tuvieron con los profesionales de salud mental. Los instrumentos utilizados fueron el WHO-ICMHC (Clasificación Internacional de Cuidados de Salud Mental), para caracterizar el Departamento, el AIESMP (Evaluación Inicial de Enfermería en Salud Mental y Siquiátrica) para obtener los datos socio-demográficos y el VSSS (Escala de Satisfacción con los Servicios de Verona) para evaluar la satisfacción de los pacientes en relación a los cuidados recibidos. El análisis estadístico incluyó un análisis descriptivo, cuantitativo y cualitativo de todos los datos.

Resultados: Las Unidades Funcionales del Departamento revelaron niveles de elevada articulación y consistencia con las necesidades de cuidados psiquiátricos y de rehabilitación sicosocial de los pacientes. Los 543 pacientes admitidos por primera vez eran en su mayoría mujeres (56.9%), caucásicas (81,2%), con diagnóstico de perturbaciones del humor (66.3%), internadas voluntariamente (59.7% y ostentaban una edad media de 45.1 años. Estas poseían significativamente más edad,

encontramos más desempegadas, casadas/en unión consensual y tenían una mayor prevalencia de perturbaciones del humor comparativamente con los hombres (54.7%). La cifra de abandono después del alta (4.2%) y la de reingresos (2.9%) en la quincena posterior al alta fue inferior al encontrado en los patrones de la literatura internacional. En general, la satisfacción de los pacientes con los cuidados de salud mental fue positiva.

Conclusiones: Los cuidados prestados mostraron ser eficaces, adaptados y basados en las necesidades y problemas específicos de los pacientes. La continuidad y la extensión de cuidados de salud fueron difundidas y mantenidas a lo largo del proceso de cuidados. Este Departamento puede ser considerado un ejemplo de cómo proporcionar tratamiento digno y eficiente y constituye una referencia para futuros servicios de psiquiatría.

Palabras Clave: Servicios Psiquiatría; Evaluación de Cuidados; Ingresos Psiquiátricos; Satisfacción de los Pacientes; Tratamiento Asertivo Comunitario.

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List of Abbreviations

AIESMP – Avaliação Inicial de Enfermagem em Saúde Mental e Psiquiátrica (Initial Nurse Assessment in Mental Health and Psychiatry)

CBT - Cognitive Behavioural Therapy

CHKS - Caspe healthcare Knowledge System

CMH - Community Mental Health

CMHT/s - Community Mental Health Team/s

DALYs - Disability Adjusted Life Years

DEMoBinc - Development of a European Measure of Best Practice for People with Long Term Mental Illness in Institutional Care

DSM - Diagnostic and Statistical Manual

ECT - Electro-convulsive Therapy

EPSILON - European Psychiatric Services: Inputs linked to Outcomes and Needs

GPs - General Practitioners – Family Doctors

HFF – Hospital Professor Doutor Fernando Fonseca

INE – Instituto Nacional de Estatística (National Institute of Statistics)

LOS - length of stay

NGO – Non-Governmental Organization

PER - Psychiatric Emergency Room

VSSS - Verona Service Satisfaction Scale

WHO - World Health Organization

WHO–ICMHC or ICMHC – World Health Organization - International Classification of Mental Health Care

INTRODUCTION

At a time of worldwide awakening to the importance and impact of Mental Health and more specifically of Mental Health Disorders, the current study materialized with the objective of assessing the Structure, Process and Outcome of a Psychiatric Department, with a special focus on first Psychiatric admissions.

Understanding the key components that constitute the quality of the mental health care rendered and the patients' satisfaction with the care received are an essential part of Service planning. Furthermore, identifying possible pitfalls is equally crucial, in that it may enlighten the mental health professionals and the service planners into going back to the basics, in other words, the main values and principles of the Psychiatric Department.

Working in the Psychiatric Department for 16 years, I am fortunate to have worked in a Community Mental Health Team for seven years, and currently the Department's Day Hospital. This experience has allowed me to gain quite significant knowledge of how mental health care is delivered, and this research is an insight into what can still be done to further comprehend and ameliorate our service and care.

The current study is divided into five parts, and whenever possible, an attempt was made to underline the Structural, Processual and Outcome components of the Psychiatric Department. The first part is the theoretical framework and revision of national and international literature, which has a purpose of laying out a backdrop on which the rest of the research, and consequently this thesis, could take centre stage. The second part is an in-depth description of the actual Psychiatric Department of the Hospital Prof. Dr. Fernando Fonseca, EPE, as well as the population residing in the Department's catchment area.

The third part is the description of the research methodology, and the presentation of the instruments used in the study. This part includes both the Objectives and Hypothesis that essentially have the purpose of providing

consistent data, which may be of use in future service planning when there is a warrant for such.

The next part of this study is the presentation of the results obtained from both the assessment instruments and the database that was created specifically for this research, but can easily be introduced into every day practice in the Department's Inpatient Unit. With the intention of avoiding repetition of data and information presented in the chapters broaching the results of the study, the discussion of the results will objectively focus on the study objectives and hypothesis, in addition to a focus on the Structure, Process and Outcome with resort to available literature. This Fourth part of the thesis also presents and analyses the limitations of the study.

The last part is constituted by a brief personal conclusion of this research process, and with the hope that this project may contribute to further research, and be of aid in future service planning.

Part 1



Review of the Literature

1. Theoretical Framework / Background

According to the World Health Organization (WHO, 2001), mental health is defined as “a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. This definition clearly expands the boundaries of the previous concept of mental health, which was defined in a very restrictive manner as “the absence of disease”. According to Sartorius (1990), mental health is better understood as a state of balance between physical, mental, cultural, spiritual and other personal factors, and between the Self, others and the environment. Furthermore, mental health is intimately related to physical health and behaviour.

The absence of positive mental health and the presence of mental health problems and mental disorders cause death, suffering, disability and exclusion from society. The World Health Report (2001) stated that Mental or Psychiatric disorders are among the top causes worldwide of disease burden and disability both for the individuals suffering from them and their families. By 2020, it is estimated that the burden of psychiatric disorders will have increased to 15% of the total Disability Adjusted Life Years (DALYs) lost due to all diseases and injuries.

This projection of the WHO (2001) demonstrates that mental disorders are common, and affect between 20 to 25% of all people at some time during their life. They are also universal – affecting all countries and societies, and individuals at all ages. The disorders have a large direct and indirect economic

impact on societies, including service costs. The negative impact on the quality of life of individuals and families is massive.

Restoration of mental health is not only essential for individual well-being, but is also necessary for economic growth and reduction of poverty in societies and countries (WHO, 2008). In 2001 through the World Health Day, World Health Assembly, and World Health Report (*Mental Health: New Understanding, New Hope*), WHO and its Member States pledged their full and unrestricted commitment to this area of public health. Also, according to Baca-Garcia et al. (2008), mental health is one of the priorities of the European Commission. Studies of the use and cost of mental health facilities are needed in order to improve the planning and efficiency of mental health resources.

Although the care of people with mental health problems has been the object of major concern over the past several decades, few countries have actually undergone the necessary major changes needed to improve the care rendered. These changes should commence with the creation of mental health care legislation, inexistent in many lower and middle-income countries, or with changes to very outdated legislation concerning the existing mental health systems, to the actual deinstitutionalization and community-based care for people suffering from mental health problems. Ensuing a long and very arduous undertaking, described in a very simplistic manner in the preceding few lines, and once all the mental health care mechanisms are in place, the next step should be the effective continuous monitorization of all available resources, in order to understand, evaluate, and improve what is actually being done. Nonetheless, to be able to understand the rationale behind this research, one must go back to the basics.

While there is still much to be done in Portugal to improve the Mental Health Care System, Portugal was one of the first European countries to develop and adopt a Mental Health Policy, which occurred in 1963 with the passing of the Law 2118. Although important steps have been taken over the past four decades, the path leading to our current situation was certainly not an uneventful one. The process of developing the Portuguese Mental Health

Policy, to what it is today, underwent three distinct phases, which will briefly be described as follows.

- The first phase began in 1963 with the new mental health law 2118, based on the principles of sectorization, which enabled the creation of mental health centres and the appearance of various important movements, such as social psychiatry and the integration of mental health in primary care. Another significant change was the regulation of compulsory treatment. Between 1985 and 1990, the first mental health program was instituted; enabling the creation of mental health centres in the big towns and a period of restructuring of psychiatric hospitals began.
- The second phase occurred between 1990 and 1995, with a counter-reform in Portuguese mental health. The strengthening of psychiatric hospitals, the integration of mental health centres in general hospitals and the dismantling of most of the community services characterized this phase.
- The third and current phase commenced in 1995 with a national debate on mental health, that produced a consensus document on mental health policy in 1997, and a year later, in 1998, the passing of the new mental health policy (Law 35/98 and Decree Law 36/99). This new mental health policy was created in accordance with the principles that were suggested by the major international organizations on the subject of mental health service organization, and at the same time, the legislation, which supported psychosocial rehabilitation programmes as well as supported employment, was also approved with the Dispatch 407/98. This was an important breakthrough due to the complete nonexistence of residences in the community and social firms for the seriously mentally ill.

Although Portugal had a very solid policy, this was not enough to implement significant change in the development of mental health services. According to WHO (2005), a policy is an essential and powerful tool, however, it can only have a significant impact on the mental health of the population it addresses when it is properly formulated and implemented through plans and programmes, which in turn, assist countries in reaching their goals. Consequently, in 2006 the government decided to create a National Mental

Health Plan Committee that would oversee the development of a Mental Health Plan, which was approved by the Council of Ministers in the Resolution no. 49/2008.

The current study is being elaborated at a time of great transformation in the health system in Portugal, namely in the reformation of the Primary Health and Mental Health Care Systems. The latter is currently undergoing a deinstitutionalization process with the concomitant creation of Psychiatric Departments located in General Hospitals, and the creation of Community Mental Health Teams, in accordance with the National Mental Health Policy (Law 35/98 and Decree Law 36/99) and Plan (2007-2016), as well as the directives of the World Health Organization (2003) that state six key principles for organizing services. Briefly, these are:

- Accessibility – services must be available locally and close to the population.
- Comprehensiveness – mental health services should include all facilities and programmes that are required to meet the essential care needs of the population.
- Coordination and continuity of care – frequently achieved through sectorization or catchment area of organization. It is extremely important for people with severe mental disorders that services work in a coordinated manner and attempt to meet the range of social, psychological and medical care needs.
- Effectiveness – guided by evidence of the effectiveness of particular interventions.
- Equity – people's access to services of good quality, should be based on need. In order to ensure equity, it is necessary to address issues of access and geographical disparities.
- Respect for Human Rights – services should respect the autonomy, should empower and encourage these people to make decisions affecting their lives and should use the least restrictive types of treatment.

According to Wing (1996), “knowledge of three broad and overlapping kinds provides a basis for planning and evaluating services. The first is the recognition of the characteristics, epidemiology and causes (biological, psychological, social) of mental disorders and any associated social disablement. The more knowledge of this kind accumulates, the easier it becomes to acquire the second, which is concerned with effective methods of primary, secondary and tertiary prevention. Both kinds of knowledge facilitate the accumulation of the third, which is efficient and economical delivery of prophylaxis, treatment and care; including enough properly trained staff, enough settings where staff and users can interact to best advantage and cost-effective planning and administration”

With this in mind, this study is being developed in a modern Psychiatric Department, located in a General Hospital, which has been actively practicing mental health care for 17 years.

2 . Setting

The setting of the current study is the Psychiatric Department of the Hospital Prof. Dr. Fernando Fonseca, a general hospital in the Municipality of Amadora, a large suburban area 10 km away from Lisbon. The Hospital is in many ways a pioneer. It was the first public hospital in Portugal to have a private administration and, it was also the first Portuguese hospital to receive international quality accreditation, namely by the King's Fund in 2001, and international re-accreditation and certification in 2009 and 2012 by CHKS (Caspe healthcare Knowledge System) Healthcare Accreditation and Quality Unit and ISO, respectively.

Even though the project for the creation of the Psychiatric Department, of the future General Hospital the Hospital Prof. Dr. Fernando Fonseca, commenced in 1993, amidst the period of counter-reform, the future Director of the Department, Prof. Dr. Graça Cardoso, was somewhat of a visionary. As a member of the *Associação Portuguesa de Saúde Mental* (Portuguese Association for Mental Health), she participated actively between 1994 and

1995 in a group that opposed this counter-reform, and which, later in 1995, would lay down the foundations for the new Mental Health Law.

According to Cardoso & Maia (2009), the first plan for the creation of the Department was presented to the Hospital's Board of Directors in 1995, which, at the time, was under public administration. This plan consisted of the organization of a Psychiatric Department that was to be developed both in the Hospital and in the Community. Later in that year, after a public contest, the administration of the Hospital was conferred to a private company, the Sociedade Gestora Amadora/Sintra, S.A., becoming, as mentioned previously, the first public Hospital to be administered by a private company in Portugal.

In accordance with the previous authors, the vision of the Psychiatric Department is to render, in a concerted manner, a range of indispensable measures of mental health care adapted to the fundamental needs of the population. In line with this vision, the main values and principles of the Psychiatric Department are:

1. Integrated response to the patients' needs on both a clinical and a psychosocial level, by resorting to individual care programmes adapted to their specific needs and problems;
2. Continuity of care;
3. Priority given to interventions in the community and to treatment in the least restrictive environment possible;
4. User and family participation in the development and rendering of care.

There have been various studies and research conducted in the Department, which have produced some objective data about the way in which the Department functions, but to date, none have addressed the simultaneous Structural, Processual and Outcome variables and indicators of the mental health care of the patients.

Taking this into consideration, and in addition to the fact that the Psychiatric Department has been operating for seventeen years, with recognition by international quality accreditation boards, the study's principal-investigator, a clinical psychologist working in the Department for sixteen years, and who has a

subjective inside knowledge about the quality of the care rendered, has designed this research project with the intention of obtaining a more accurate depiction and evidence, on the effectiveness of the Department, as well as patients' satisfaction with the care received.

3 . State of the Art and Innovative Aspects of the Study

The innovative aspect of this study is that its objective is to address all of the aspects of the mental health care delivered by a Psychiatric Department, namely the Structure, the Process and Outcome. Thus far, and to the author's knowledge, there are no studies or research projects of this kind in Portugal.

According to Donabedian (2003) the structure-process-outcome model, which was developed to assess clinical practice, "is not always properly understood", therefore he states that structure, process and outcome are not attributes of quality, and "they are only kinds of information one can obtain, based on which one can infer whether quality is good or not". Donabedian continues and affirms, "Inferences about quality are not possible unless there is a predetermined association among the three approaches, so that structure influences process and process influences outcome.

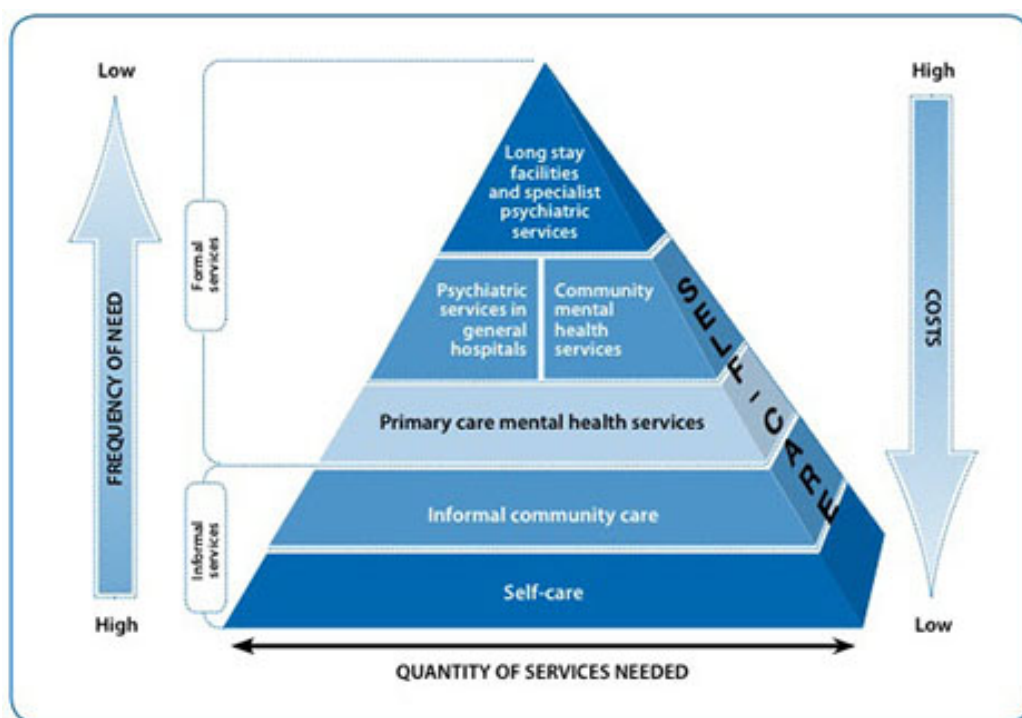
4. Structure – Revision of the Literature

According to Tugwell (1979) and Donabedian (2003), the Structural level, which may also be denominated as the resource level, refers to the general frame that defines the working conditions of the system. On one hand, it includes the Sociodemographic characteristics of the population, and on the other, the human, physical and financial resources of a health system.

Portugal is currently undergoing major change with the organization and creation of a more effective mental health system, with the aim of meeting the

mental health needs of the population. This process is being developed under the aegis of the WHO, who has developed the “Optimal mix of services pyramid” framework to provide guidance to countries on how to organize services for mental health (Who, 2007). According to this framework (Figure 1), the majority of mental health care can be self-managed or managed by informal community mental health services¹. When further expertise and support are needed, a more formal network of services is required. These include, primary care services, at the base level, followed by specialist community mental health services and psychiatric services based in general hospitals, and lastly by specialist and long stay mental health services.

FIGURE 1 - THE WORLD HEALTH ORGANIZATION'S "SERVICE ORGANIZATION PYRAMID FOR AN OPTIMAL MIX OF SERVICES FOR MENTAL HEALTH"



In accordance with the WHO (2007), the most frequent care in the WHO pyramid framework should be self-care². To facilitate the autonomy and ability of people to care for themselves, the health service or NGOs need to provide

¹ for example, community groups, religious organizations and schools.

² This means that people manage their own mental health problems or with help from family or friends. As far as possible people need to know how to limit contact with 'high-risk' situations that may likely affect mental health negatively, develop skills to manage stress, have the ability to discuss and manage emotional problems as they arise, and know when to seek help and from whom to seek help.

information to people. This should be available and accessible to all people through, for example, radio and television shows, or leaflets that are distributed in language and literacy levels that people understand.

The next level is the existence or creation of informal community mental health services, which are services provided in the community but that are not part of the 'formal' health and welfare system³. This level is also extremely important for 'down-referral'⁴. Informal services are usually accessible and acceptable to the community, as they are an integral part of the community.

The next level is the integration of mental health care into primary health services. This is a critical component of comprehensive mental health care, as the essential services that constitute this level enable early identification of mental health disorders, management of stable psychiatric patients, referral to other levels when required, as well as promotional and prevention activities⁵. Seeking and receiving treatments, as part of general health care, is also less stigmatising for the individual, especially in cultures or societies where having a mental disorder is regarded as shameful. From a clinical perspective, it has been found that most common mental disorders can be treated at this level. Notwithstanding, integration of mental health into primary health care requires careful training and supervision of staff. In communities where there is no integrated first level formal care, additional pressures are put on the higher levels of care. This may mean that people are wrongly referred to higher and more specialised levels of care that should be dealing with more complex problems. On the other hand, where there is no early identification of problems, treatment or prevention and promotion, more people become seriously ill, and need to be treated at higher levels.

The fourth level of the pyramid is related to the development of mental health services in general hospitals, and the development of community mental

3 Examples of this may be traditional healers, professionals in other sectors, such as teachers, police, village health workers, services provided by NGOs, user and family associations, and laypersons.

4 - For example, people who have been treated in hospital, and discharged, often need informal support to prevent relapses, or need care at a higher level.

5 - Mental health services at this level significantly increase physical accessibility, since this first level of general health care is usually reasonably close to where people live. Furthermore, the person can be treated as a whole person, who may have co-morbid physical and mental health problems.

health services⁶. Although there are many advantages, one cannot forget that this solution also has some limitations. The first limitation is related to the fact that general hospital services can manage acute episodes of mental illness, but do not provide a solution for people with chronic disorders, who may become revolving-door patients, unless they are backed up by primary health services or community mental health services. The second limitation has to do with the fact that normally the general hospitals are located in district headquarters or big cities, and this may create access problems. On this level, as mentioned previously, it is of vital importance the development of 'formal' community mental health services⁷. Whilst not all community mental health services will be able to supply all of these services, a combination of some of these, based on needs and requirements, is essential for mental health care. Good community care has been shown to have better health and mental health outcomes, and patients have better quality of life than those treated in institutions. As part of the mental health system, represented by the pyramid of care, it is important that the community mental health services have strong links with other services such as informal care, as well as with both primary health care and general hospital services (WHO, 2007).

Once all of these services are in place, a planned and gradual transition, from a predominantly institutionally based service model to a model that provides treatment and care through community services, general hospitals, and most importantly through primary healthcare, should occur. Due to their high costs, poor clinical outcomes and human rights violations, mental hospitals represent the least desirable use of scarce financial resources that could be put to better use in the services described previously.

At present, in Portugal, mental health services are functioning on all of the levels shown in Figure 1. Further in this study, work being developed on the

6 - In relation to the former, given the nature of mental disorders, for a number of people some hospitalisation, during acute phases of their condition, may become necessary. Any co-morbid conditions can easily be treated and special investigations can be conducted.

7 - These services may be: day centres, rehabilitation services, hospital diversion programmes, mobile crisis teams, therapeutic and residential supervised services, group homes, home help, assistance to families, amongst other support services.

Service level, of the Psychiatric Department of the Hospital Prof. Dr. Fernando Fonseca, will provide an ongoing practical example of a Service that is constantly working towards the main objective of meeting the mental health needs of its population.

5 . Process – Revision of the Literature

Over the last several decades, the interest in evaluating mental health care processes has greatly increased (Jong, 2000; Piotrowski et al., 2009). According to Jong (2000), “somewhat surprisingly however, most of the literature published, focused on the first and third level of the mental care process, this is, the problems presented (diagnosis) and the outcome of the process after the interventions provided by the mental health care system. The second aspect, the process of providing care itself, was mainly described in very little detail.

The Process level refers to all of the diagnostic, therapeutic and preventive activities that are carried out in mental health care. The Process also includes the system’s dynamics: the flow of patients, the patterns of service use, continuity of care, and the integration and coordination of all of the care mechanisms”.

5.1. Pathways to Care

Integrated care pathways is a well developed concept in non-psychiatric specialities, consisting of a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient, with a specific condition or set of symptoms, move progressively through a clinical experience to positive outcomes (Middleton and Roberts, 2002). In mental health in general, there are few integrated care pathways, since routes of access to help are diverse and varied, and may involve non-health agencies such as social services and the

criminal justice system Singh and Grange (2006), and housing services (Morgan et al., 2004).

Rogler and Cortes (1993) define Pathways to Care as “the sequence of contacts with individuals and organizations prompted by the distressed person’s efforts, and those of his or her significant others, to seek help as well as the help that is supplied in response of these efforts”.

Amaddeo et al. (2001) affirm that the careful analysis of pathways to specialist mental health care, particularly in community-based services, is important since it promotes an understanding of the inter-relation between the parts that constitute the whole system of care. Furthermore it can also support informed decisions about resource allocation, and describe the *actual* referral routes, rather than those which are planned or intended. This is fundamental particularly for new episodes of care, where new patients often do not know how to gain access to treatment and care.

Goldberg and Huxley have identified the sequential filters to help-seeking pathways that may account for the delays in treatment. Individual, family, social and cultural factors all may be relevant in determining, if and when, help is sought and who is consulted. According to Steel et al. (2006), and numerous other studies (Commander et al., 1997 & 1997; Morgan et al., 2004; Alexandre et al., 2010; Wit et al., 2012; Mohan et al., 2006; Snowden & Holschuh, 1992), belonging to an ethnic minority may also influence the pathways leading to psychiatric services and service use.

In the era of clinical governance and quality assurance, understanding pathways to care is a crucial first step in ensuring improved clinical decision-making and effective service delivery (Singh & Grange, 2006).

5.2. Psychiatric Emergency Room - PER

According to Bruffaerts, Sabbe & Demyttenaere (2005), the deinstitutionalization process has resulted in a decrease in the length of stay in

psychiatric hospitals, and an increase in the number of psychiatric patients living in the community. Whereas before, one of the main functions of the Psychiatric Emergency Room (PER), was to triage patients with severe mental illness to more appropriate settings, over the last decade the PER has evolved due to the help-seeking tendencies of the patients with mental disorders.

The clinical profile of the PER patients seems subject to a progressive change: it seems to have become a central entry point for a wide range of patients, or “for both the worried well and the acutely psychotic patient” (Larkin et al.,2005), meaning there has been a great increase in the number of patients that attend the PER annually. This trend has been observed in both the United States and in Europe. According to these authors over the last decade the incidence of mental disorders in the community has stabilized, whereas the proportion of persons seeking help for these disorders has increased significantly. This increase is in great part due to less severe disorders that used to be relatively scarce in the PER, namely mood and anxiety disorders.

Bruffaerts, Sabbe & Demyttenaere (2005), carried out a study on the characteristics of PER users. The result show that of 3719 patients that visited the PER between March 2000 and March 2002, 63.7% were “incident users” and 36.3% were “recurrent users”. The mean age was 38 years and females represented 55% of the sample. Nearly 73% was married or living with someone, and 66% of the sample was unemployed. Recurrent users were more likely to be unemployed, to be living alone, to present with substance abuse, and auto and hetero-aggressive behaviour when compared to incident users. In this study, recurrent users were much more likely to have used inpatient and outpatient services in the past. Moreover, 12.1% of the recurrent users reported that they had never received previous treatment, compared to 49.6% of the incident users. Of the initial sample, about 44% were admitted for inpatient treatment. In those patients who were admitted 90.6% were voluntary admissions, whereas the remainder 9.4% were involuntary admissions. Almost twice as many recurrent users were involuntary admissions when compared to incident users (13.4 vs. 7.6%; Fisher Exact Test, $p=0.001$).

Of all patients presenting to the PER in over 32% of the cases this was their first mental health treatment contact. With this in mind, the question arises

about which factors induced a repeated utilization of the PER: was there a lack of adequate social support, were aftercare arrangements at the previous referral inefficient to keep patients away from the PER, were the services that they already used insufficient in addressing their needs, or were repeated PER visits inherent to their emotional problems? Earlier studies show that patients who received continuous care after a PER referral or a psychiatric hospitalization, resided a longer time in society than those without such care (Bruffaerts et al., 2005). In line with these studies, Lay et al. (2006) conclude that it has been known for some time that underprivileged patients often use psychiatric (especially emergency) services and many of the problems of multiple-admission patients are rooted in social disadvantage.

5.3. Inpatient Admission and Care

According to Johnstone and Zolese (1999), “first-ever admission to a psychiatric facility represents a major personal event for patients and their families, as well as a very expensive form of psychiatric treatment”. In addition, Guzzetta et al. (2010) state that it is a well-known fact that the characteristics of this first contact with psychiatric services are good predictors of the subsequent course of illness.

Several factors have been advanced as contributing to the admission to a psychiatric inpatient facility (Bowers, 2005), namely:

- Dangerousness - risk to self or others;
- Assessment – need of diagnostic assessment;
- Medical treatment – which may include administration of medication or electroconvulsive therapy;
- Severe mental disorder – symptomatic behaviour that cannot be managed in the community;
- Self-care deficits and self-neglect;

- Respite for carers – mainly due to an increase in family burden, which in many cases may not be attributed to an increase in severity of the patients' symptoms but to other stressful family life-events;
- and Respite for the patient – the admission may be made to remove the patient from an environment that is worsening his mental illness, or is otherwise psychologically noxious.

Nonetheless, very little is known about first-ever psychiatric admissions. According to Guzzetta et al., (2010), and Ballerini et al. (2007), most studies on first-ever admissions have focussed on specific diagnostic groups of patients, and very few have investigated the sociodemographic, clinical and treatment related characteristics, as well as the reasons leading to first-ever admission, in non-psychotic patients or in a (diagnostically) heterogeneous sample of first-ever admitted psychiatric patients. The former authors, as part of the PROGRES-Acute project, funded by the Italian Ministry of Health and jointly coordinated by the Italian National Institute of Health and the Department of Mental Health of Trieste, have carried out a study concerning first-ever admitted patients in 21 Italian regions, during the index period in the year 2004. The aims of this study have similarities with the research of this thesis.

In this study by Guzzetta et al. (2010), of all the psychiatric admissions to inpatient facilities in Italy, 21.4% (N=337) were first-ever admissions. Of these, 55% were male, and the mean age at admission was 42.1 years. More than 60% were younger than 44 years, and more than 40% were between 24 and 44 years of age. About 50% of these first-ever admitted patients had received some kind of treatment during the month prior to admission, and most (82.1%) were voluntary admissions.

In the Suffolk County Mental Health Project, (Mojtabai et al., 2005), results showed that 43% of the first-ever admitted patients (N=573) were readmitted at least once during the 48 month follow-up. The median number of readmissions was 2, with a range from 1 to 12. Although there was a decline in the number of inpatient days, this was mainly due to reduced LOS, rather than reduced frequency of admissions.

Carr et al. (2003) state that the factors associated with multiple readmissions includes the number of previous admissions, longer inpatient stay, and a

diagnosis of psychosis, or personality disorders (Korkeila et al., 1998). Studies analysing psychiatric service use, have repeatedly found that 10 to 30% patients “consume” between 50 and 80% of service resources. (Lay, Lauber & Rössler, 2006) Possible risk factors for heavy psychiatric use, are the number of previous admissions, moreover, psychotic disorders as well as comorbid Diagnostic and Statistical Manual (DSM) axis-I diagnosis, and in particular high levels of drug and alcohol misuse are also associated with heavy use (Lauber & Rössler, 2006; Baca-Garcia et al., 2008). These authors also conclude that studies focusing on sociodemographic aspects of help seeking behaviour suggest various social risk factors that increase the chances of repeated psychiatric service use. Younger age, unemployment and living alone or homelessness, may be stronger correlates than certain clinical diagnoses.

Although there is an expansion of community care, some patients seem to need long and frequent psychiatric admissions. Carr et. al. (2003), referring to a Finnish study, by Saarento et al. published in 1997, concluded that of the 537 new patients in the follow-up study, 5 percent met the criteria for “revolving-door” patients, and the readmission rates were higher among the patients who had diagnoses of psychosis and personality disorders. In this study, 2% of the cohort became long-stay patients, and this outcome was predicted by psychiatric diagnosis. Research concludes that the factors, which may delay psychiatric discharge, are psychiatric diagnosis, but add that other medical conditions as well as behavioural problems, such as severe substance abuse or medication noncompliance, as well as dangerous behaviour when not supervised, may weigh significantly when assessing readiness for discharge Fisher et al. (2001). Trieman, Leff & Glover (1999) also conclude that long-term inpatient care will still be needed when psychiatric institutions have closed. A systematic review performed by the DEMoBinc European study, (Taylor et al. 2009) showed that long stay patients vary between 2 and 50%. These patients deserve attention, because they make considerable demands on psychiatric resources, on personnel, and their care is expensive, not only in terms of hospital beds occupied but also in terms of sickness benefits and disability pensions. This study group also concluded that the ideal institution for these patients “would be based in the community, operate a flexible regime, maintain

a low density of residents and maximise residents' privacy". This group also advocates the need for Cognitive Behavioural Therapy (CBT), family interventions involving psychoeducation, and integrated supported employment, amongst other interventions (Taylor et al., 2009).

5.4. Voluntary versus Compulsory admission

Involuntary hospital admissions have been part of modern psychiatry since its beginnings more than 200 years ago (Katsakou & Priebe, 2006),.

Compulsory admissions of psychiatric patients, which are increasing in many European countries is a topic in mental health care currently facing strong criticism particularly by human rights advocates (Salize & Dressing, 2004; Post et al., 2008). This is an undesirable trend, which not only leads to a very negative experience for the patient, and a reduction of her/his autonomy, but also has a negative effect on the prognosis of these disorders (Post et al., 2008). A number of interacting factors are believed to be associated with the risk of coerced admission Klinkenberg & Calsyn 1996; Cougnard et al.,2004). In short, these are:

- Patient vulnerability, which can be defined by individual patient characteristics such as type and severity of psychopathology, and sociodemographic factors;
- social support, in that, higher levels of social support may reduce the risk of (compulsory) admission;
- 'responsiveness' of the health care system;
- and "willingness" to receive treatment or treatment adherence, which, in psychiatry as in the whole of medicine, is a major problem, since treatment non-adherence has very significant implications for the delivery of adequate care, patient prognosis and health care costs.

The results of a systematic literature review on involuntary versus voluntary hospital admission (Kallert et al., 2008) demonstrate that most involuntarily admitted patients showed substantial clinical improvement, and that a

significant number of patients did not feel retrospectively that the admission was justified and/or beneficial. This systematic review qualified 41 out of 3227 references found in Medline and PSYINDEXplus, and the authors analyzed the available data on three distinct levels: Service-related outcome domains; Clinical and observer-based outcome domains; and Subjective outcome domains. On the Service-related level, in general, studies showed that length of stay (LOS) for patients admitted compulsorily was at least as long as, or longer, than for patients admitted voluntarily. The likelihood of compulsorily admitted patients being readmitted was at least as high, or higher, than for those admitted voluntarily, and the risk was even higher in patients with compulsive index-admissions. On the level of clinical and observer-based outcome domains, compulsively admitted patients, showed either, a comparable or lower level of social functioning both at admission and at discharge, but their improvement was in the same range as for those voluntarily admitted. Furthermore, there were no group differences in terms of general psychopathology, treatment compliance or medication compliance. On the level of subjective outcome domains, the systematic review demonstrated that compulsively-admitted patients were significantly less satisfied with important aspects of their treatment than voluntarily-admitted patients, a greater number of voluntary patients versus compulsive patients significantly felt that they needed hospital treatment.

Another, smaller review-paper (Katsakou & Priebe, 2006), concluded that on average, involuntarily admitted patients did show clinical improvement and, at follow-ups viewed their admission and treatment rather positively. However, in the various studies reviewed between 6% and 33%, retrospectively, did not feel that their admission was justified and beneficial. Some studies suggest that the length of time between compulsory admission and follow-up interviews might be an important factor influencing self-rated outcomes, since patients appear to report more positive views when interviewed after longer periods.

5.5. Attendance at First appointment after discharge

According to Kruse & Rohland (2002) and Callaly et al. (2011) “the period between discharge from an inpatient setting and engagement in community services is a critical and vulnerable time for the continuity of care of persons with mental illness. Failure to engage in outpatient care after discharge has been shown to increase the likelihood of readmission, and can compromise successful community adjustment. In fact, Nelson and colleagues (2001), demonstrated that patients who did not attend an outpatient appointment after discharge were two times as likely as those who kept at least one outpatient appointment to be readmitted during the same year. According to these authors, evidence suggests that a longer period from contact to appointment may be associated with non-adherence. Other factors associated with non-adherence, according to a systematic review performed by Nosé et al., (2003) are lack of insight, positive symptoms, younger age, male gender, and history of substance abuse, unemployment and low social functioning.

Compton et al. (2006) pointed out four characteristics that were independently significant predictors to non-attendance of first appointments after hospital discharge were:

- involuntary legal status at discharge or leaving against medical advice;
- not having an established outpatient clinician;
- axis IV problems related to the primary support group;
- and number of days from hospital discharge to the follow-up appointment.

In fact each additional day between discharge and the follow-up appointment increased the odds of non-adherence by about 4 percent. Aftercare programmes that provide early follow-up appointments after discharge may confer overall cost savings to local mental health systems by decreasing the risk of non-adherence and subsequent readmissions. Another essential factor that improved adherence to outpatient appointments is the inclusion of the outpatient clinician in discharge planning meetings with the patient, in the hospital before discharge (Nosé et al., 2003). This system-related practice is in accordance with other author’s findings (Kruse & Rohland, 2002), suggesting

that scheduling the appointments within two weeks of discharge may increase the likelihood of attendance.

5.6. Continuity of Care in Mental Health

According to Bachrach (1981), “continuity of care can be defined as a process involving the uninterrupted movements of patients over time through the diverse elements of the service delivery system”. For several years the continuity of care model has gained acceptance as the best answer to the problems of service delivery in the community for the severe, long term mentally ill (Barbato et al., 1992). Such definitions, recognise the need to encapsulate both longitudinal (continuity over a period of time) and cross-sectional (continuity between different aspects of services) components of care. (Thornicroft & Tansella, 1999). Efforts to provide continuity of care can be made through providing continuous and consistent contact with a particular service or team, or by trying to ensure that services are delivered by the same person within a given service (Johnson et al., 1997).

Crawford et al. (2004) developed a definition consisting of five items. The first three items relate to longitudinal continuity of care: the patient remains in contact with the services; there are no breaks in service delivery, and the patient sees the same member of staff. The fourth item refers to cross-sectional continuity and states that the different components of health and social care are coordinated, and the final item relates to the experience of users and carers, stating that service users experience care as smooth and uninterrupted. These authors also concluded that service users emphasised the need to provide flexible care and to act quickly at times of crisis. Other mechanisms for providing continuity of care included the ability to *smooth transitions* (where workers try to minimise the impact of changes in service provision) and ‘contextualizing’ (where service providers who have known the patient over a long period of time, help others working with the clients to reframe problems in a way, which recognises previous gains). This finding was also supported by a previous qualitative study by Kai & Crosland (2001) in which in-depth interviews

were used to explore how people with severe mental health illness experienced healthcare. Continuity of care from the same professional emerged as a central theme. Patients reported that they needed to be able to build a continuing relationship with one person over time and expressed concerns about changes in physicians and the need to give repeated accounts of their previous problems and treatment.

Recent studies support the view that integration between hospital and community services is a viable, economically convenient solution to improving delivery of care by mental health services. Furthermore, studies have led to suggestions that hospitalization should only exceptionally represent the entry point in the system – ideally, patients should be given inpatient care as a last resort after the failure of community treatment (Tyrer et al., 1989)

Barbato et al. (1992) and Ruggeri et al. (2007), affirm that comprehensive community mental health services seem to offer good continuity of mental health care to patients with severe mental illness, but they do not dedicate sufficient attention to patients with less severe symptoms and less disability. Ruggeri et al. (2007) suggests that the consequent persistence of untreated psychopathology and disability in patients affected by mild-to-moderate mental health problems, who have sought help from a public health service, is likely to cause high subjective distress and higher direct and indirect social costs. In Portugal, in accordance with directives of the WHO as well as the Portuguese Mental Health Policy and Plan, patients with milder mental health problems (such as anxiety and depressive disorders) should be treated by their GPs (General Practitioners – Family Doctors) in Primary health care, to reduce the direct and indirect costs associated to these mental health problems. Due to the very significant prevalence rates of mental illness in Portugal, there is an ever increasing and significant role to be played by the Family physicians. This participation allows the mental health services further accessibility to practice more effective, comprehensive and continued care for patients suffering from moderate-to-severe mental illnesses. Joyce et al. (2004) and Barbato et al. (1992) concluded that on the whole, integration is more likely to materialise for patients with severe mental health disorders and a previous history of psychiatric treatment, as well as the ‘revolving door’ patients.

Continuity of care is widely regarded as central to the provision of mental health services (Durbin et al., 2004; Barbato et al., 1992). These authors conclude that clinicians commonly assume that if continuity of care is absent from the services provided to patients with chronic and debilitating conditions, the result may be social isolation, economic hardship and threats to quality of life.

5.7. Treatment Discontinuity / Drop-outs

A prerequisite for good treatment outcome is continuity of care. Ruggeri et al. (2007), have provided evidence that a community based mental health service based on an integrated and need-led care approach, can satisfactorily cope with the challenge to engage continuously in care those who are more severely ill.

Nevertheless, premature termination of outpatient psychiatric treatment is relatively frequent. In a review by Berghofer et al. (2002), between 22% and 63% of patients, are reported either with a new episode or first-ever treatment, dropped out after only one service contact. The percentage of dropouts increases over the first 3 months after the first contact, and this lead to a percentage rate of between 18% and 50% of continuing patients. After 6 months, this rate stabilized to around 25% to 40% (Lerner et al., 1993).

Research aimed at attempting to identify which variables predict treatment continuity or discontinuity, have not produced consistent results. Berghofer et al. (2002), refer that patients with a diagnosis of schizophrenia were 22 times less likely to drop out of treatment, than patients with other diagnoses. Young et al. (2000), found that patients that older patients and those with a diagnosis of schizophrenia were more likely to remain in treatment. The former authors also found that the availability of home care, living alone, and a high quality in the patients' living situation, as well as in relations to family and significant others, reduced the risk of dropout. Unemployment, previous psychiatric admissions, low patient satisfaction with staff competence, and high

self-ratings of global functioning were positively associated with treatment dropout. Contrarily, longitudinal studies in the USA, Britain and Denmark, referred by Crawford et al. (2004), have shown that male gender, younger mean age, lower socio-economic status, belonging to an ethnic minority, being unmarried, socially isolated, having comorbid substance abuse, shorter duration of illness, amongst others, were associated with increased rates of dropout.

Ruggeri et al. (2007) have also concluded that patients reported dissatisfaction with the service as one of the main reasons for dropping out. Young et al. (2000) selected a random sample (N=47) of the patients that had dropped out of treatment (N=554 of the total sample of N=1.769), and interviewed them, to question their reasons for interrupting treatment. These respondents gave 73 reasons, and some gave more than one reason. The most frequent reasons were that *they had improved* (32%), *were having problems with the clinician* (30%), *were having problems with the treatment* (23%), *family problems with the clinician* (9%), or *had left the area* (26%). Barriers to treatment were cited by only 21% of the patients, and included cost, transportation problems, comorbid disorders, and bureaucratic issues.

Patients who discontinue treatment are a serious problem, both in general and mental health settings. Inappropriate discontinuation of health care may lead to wasted resources, and may worsen patients' outcome. Identifying the reasons for treatment dropout and its impact on outcome is an essential task. This enables the creation of health care policies aimed at promoting adequate completion of treatment and improving treatment effectiveness. (Ruggeri et al., 2007; Berghofer et al., 2002).

5.8. Migration and Ethnicity

According to Bhugra & Jones (2001), "migration is the process of social change whereby an individual moves from one cultural setting to another for the purposes of settling down either permanently or for a prolonged period. Such a shift can be for any number of reasons, commonly economic, political or educational betterment. The process is inevitably stressful and stress can lead

to mental illness. The preparation the migrants undertake, their acceptance by the new host community and the process of migration itself are some of the macro-factors in the origin of mental disorders. The micro-factors include personality traits, psychological robustness, cultural identity, and the social support and acceptance of others in their own ethnic group.”

For many decades, research in mental health has focused on the pathways to care by ethnic minorities. In the current study, this matter cannot be overlooked due to the very significant migratory history in Portugal. According to the preliminary results of the 2011 population census, just over 10% of the population in the Psychiatric Department’s catchment area are immigrants, therefore, the need to understand whether the immigrant population displays the same patterns, pertaining to the pathways to mental health care, as in other countries. The conclusions of a longitudinal retrospective study conducted in the Psychiatric Department of the HFF, by Alexandre et al. (2010), which reviewed the medical records of all the patients admitted between the 1st of January 2004 and the 30th of June 2007, state that black immigrants were over represented in the inpatient population. Of the inpatients, 19.6% were black, whilst, according to the 2001 census, the percentage of first generation African immigrant population in Amadora was 10.5%. Black patients were younger and more frequently male, had more frequently diagnoses of schizophrenia and acute or transient psychosis, and were diagnosed less frequently with delusional and personality disorders than white inpatients. These results are consistent with previous research in the USA and the UK. According to Al-Saffar et al. (2004), “psychiatric diagnoses are not entities, but are given to describe observations and at the same time offer meaning to observations. The observations and the interpretations thereby become inseparable. It is obvious that cultural bias may influence the process”. They also conclude that ethnicity has a strong impact on how diagnoses are given in cross-cultural settings.

Commander et al. (1997) found that ethnicity had a marked influence on the access to care and the use of specialist mental health services. These researchers concluded that one of the main problems with the ethnic minorities, especially black population, was the poor level of case recognition by the GPs. Furthermore Morgan et al. (2005b) conclude that compared with white British patients, GP referral was less frequent for both African-Caribbean and Black

African patients. In fact, referral was less than half than for the white British patients.

In a study by Snowden & Holschuh (1992) blacks made use of the PER more frequently than whites, and were also hospitalised more frequently. After controlling for potentially confounding factors, such as history of service use, sociodemographics and diagnosis, the results showed that black patients averaged about 1.1 more trips to the PER and about 50% additional hospitalisations than whites. This study also concluded that blacks were found to have made fewer visits than whites for case management and individual therapy. Differently Mohan et al. (2006) found no significant differences in the use of different community services. According to them, the relatively heavy PER use by blacks reflects a general tendency within this ethnic group to rely on emergency care. The urban poor, and blacks in particular, are heavy users of the PER because of lack of access to Family Physicians or GPs. Black patients also have more compulsory admissions than other ethnic groups studied (Wit et al., 2012, Mohan et al., 2006, Commander et al., 1997, Morgan et al., 2005a). Moreover this risk was even greater in second-generation migrants (Wit et al. 2012, Morgan et al., 2005a).

In the study by Mohan et al. (2006), a higher proportion of African-Caribbean patients had a history of detention under the Mental Health Act (77% compared to 49% in white patients, $P=0.003$), and they had been in contact with the services for a significantly shorter period. Although the two groups did not differ in the mean number of admissions, the African-Caribbean had a higher LOS during the prior year than whites (mean of 34 vs 16 days), but not reaching statistical significance ($p=0.065$). These researchers also found differences between the two ethnic groups in their sociodemographic characteristics, namely African-Caribbean patients were more likely to be younger, confirming other studies, married, and to have more children. However, although there were differences in clinical characteristics, the two ethnic groups were comparable on global measures of severity.

Most of these studies are congruent in the sense that they all, in one way or another, emphasize “the need for more culturally sensitive care in mental health services” (Alexandre et al., 2010).

6. Outcome – Revision of the Literature

The Outcome level includes the psychopathological and social changes that occur in the patients, the degree of satisfaction they feel towards themselves and their quality of life. According to Torres-González (1997) it is also of interest to know whether the patients are aware of these changes, what degree of satisfaction do these changes produce, and in what ways do they have repercussions on the patients’ quality of life. This author also broaches the matter of whether these changes experienced by the patients truly represent an answer to the patients’ previously assessed needs. Donabedian (2003), classifies the Outcomes in a much more thorough manner. According to him, the Outcomes may be: a) Clinical; b) Physiological-Biochemical; c) Physical; d) Psychological – Mental; e) Social and Psychological; f) Integrative Outcomes; and g) Evaluative Outcomes.

6.1. Satisfaction with Mental Health Care

Bergner et al. (1997) and Goldberg & Huxley (1980) stated that “Dissatisfaction with the information provided in long-term psychiatric illness, by traditional indicators of outcome such as mortality and morbidity rates, facilitated the use of data on the **Structure** (physical layout, economic resources, personnel available) and, mainly, on the **Process** (service utilization) of care as indicators of Outcome. The rationale for this idea was, on one hand that illness severity is linearly correlated with service utilization and, on the other, that service utilization is linearly correlated with outcome. Nowadays it is clear that outcome and service utilization are not linearly correlated and that

service utilization may depend on many variables other than outcome, such as patients' sociodemographic characteristics, relationship with professionals, resources available and 'intrinsic' characteristics of the service itself".

More recently, Eaton (1996) stated that the utilization measures like the volume of Service, rate of hospitalization and community treatment in addition to satisfaction with services/treatment, are important measures of outcome on the service level.

According to Ruggeri & Tansella (1996), "a variable that is receiving increasing attention by researchers is *satisfaction with services*. As early as 1966 Donabedian stated that "(...) the effectiveness of care in achieving and producing health and satisfaction, as defined for its individual members by a particular society or subculture, is the ultimate validator of the quality of care". According to Sheppard (1993), "patients' satisfaction with services represents a general sense in which the clients, overall, felt positive or negative about interventions", and satisfaction with services may be viewed as a desirable outcome of care. Further, satisfaction may illuminate results obtained when measuring other outcome variables (psychopathology, social functioning, quality of life or burden on relatives). Lebow (1983 *in* Ruggeri & Tansella, 1996), wrote that "a significant association between the level of patient satisfaction and treatment outcome was found in a few studies".

"Client satisfaction with services can be considered an independent or a dependent variable. As a *dependent* variable, satisfaction has been hypothesised to be the effect of various factors such as subjects' expectations with services, subjects' attitudes toward life, self-esteem, illness behaviour and previous experiences with services, besides depending on the structure, the process and the outcome of care. As an *independent* variable, satisfaction can influence the efficacy of interventions and various behaviours of consumers such as compliance and service utilization" (Ruggeri, 1994). Notwithstanding this reflection, only recently have consumers' views been regarded as relevant to service assessment. Sheppard (1993) summarized, in six points the reservations about the use of patients' satisfaction as a means for assessing interventions:

- “The concept of satisfaction is too general to provide a meaningful guide to the way clients think;
- Satisfaction may be related to the way a service is given rather than the outcome (positive or negative) of the intervention;
- Some clients may pronounce themselves satisfied, knowing little of the alternatives available;
- In some cases, merely asking people to rate something can produce a favourable evaluation and cause bias in the measurement;
- Individuals’ comments are the prisoner of the moment; what they say on one occasion may be different from another occasion;
- The degree of satisfaction may owe more to the clients’ cultural background and expectations than their actual experience of intervention”.

These reservations show that even today, and even among many mental health professionals, there is still discrimination towards mental illness, in that sometimes these patients are treated as though they have been completely deprived of the ability to make careful and rational judgements. Fortunately, this reality is gradually changing, and greater emphasis is being placed on patients’ and families’ opinions and choices. This is essential when considering, planning, and working on a needs-based mental health system. Lora, Rivolta & Lanza (2003) showed that satisfaction is a useful indicator in monitoring quality of care: by analysing different dimensions of satisfaction, we can focus professionals on patients’ needs and expectations and modify the services accordingly.

The results of the Satisfaction with mental health services, part of the research conducted in the EPSILON Study will be highlighted due to their implications and significance as a measure of outcome. The EPSILON (European Psychiatric Services: Inputs linked to Outcomes and Needs), Study was a comparative, cross-national, cross-sectional study of the characteristics, need for care, quality of life, caregiver burden, patterns of care, associated costs, and satisfaction levels of people with schizophrenia in five European sites, which are Amsterdam, Copenhagen, London, Santander and Verona (Ruggeri et al., 2003). These authors concluded that satisfaction with services

varied substantially across the sites, and after adjusting for patients' background characteristics, found that the variability may be related to the different characteristics of mental health services and the social environments across the sites. In fact, the five sites differed widely with respect to culture and economic factors, national health care systems, mental health service organization, and service provision. This study has been able to identify the strengths and weaknesses, from the perspectives of the patients, of each mental health service assessed, and have demonstrated that they differ in many respects. In particular, involvement of relatives in the process of care, and information about illness were the satisfaction domains where the mental health services in most sites showed the worst performance (Ruggeri et al., 2003). Patients perceived that relatives were not sufficiently involved in the process of care. Therefore, involving family members in the process of care and being prepared to take account for their needs are crucial to successful community care provision. Furthermore, the lack of information given to patients, and their families, by mental health services is an important and complex issue. A study on caring behaviours by Von Essen & Sjoden, (1995) concluded that psychiatric staff rated "explanations" as the least important caring behaviour. Ruggeri et al. (2003), also state that it is common in clinical practice for professionals not to give all of the information that patients need about their diagnosis and prognosis. This may be due to the fact the professionals assume that no information is required when the patients do not explicitly seek advice and information. Ultimately, when information is given, it may be provided in a partial or over simplistic way.

The EPSILON Study has also found that higher illness severity is cross-culturally associated with lower service satisfaction, especially in the domains assessing the involvement of family members, and self-perceived efficacy of the service. High satisfaction with life had, after study site, the strongest and most positive association with service satisfaction. Interestingly, domains very likely to be affected by severe mental illness, such as quality of social relations and quality of health, were those with the highest impact on satisfaction with services.

Lora et al. (2003), in their research in the Desio Department of Mental Health in Milan, with a sample composed of patients with heterogeneous psychiatric diagnoses, also utilizing the VSSS (Verona Service Satisfaction Scale), concluded that patients were more satisfied (a mean of more than 4 points) regarding items related to confidentiality and respect for patients' rights. The personal manners, professional knowledge, and competence of the psychiatrists and psychologists, the kind of services offered, the behaviour and manners of reception or secretarial staff, the personal manners of nurses, the thoroughness of the various professionals, the opportunity to meet alone on a regular basis with the therapist, the ability of psychiatrists and psychologists to listen and understand the patients' problems, and the overall sense of service received, were also dimensions in which satisfaction levels were significant. Although there were no significant differences between diagnoses either in total score or in single VSSS dimensions, patients with personality disorders revealed a trend in the direction of less satisfaction, and the lowest means in all dimensions. Ruggeri et al (2007) also noted that psychiatric diagnoses did not seem to have significant impact on the satisfaction, with the only exception of the 'access' dimension, with non-psychotic patients reporting lower satisfaction.

Ruggeri et al. (2003), data supports the view that service satisfaction can be seen as the combined result of:

- (a) The ability of the service to provide a standard of care above a certain quality threshold (e.g., in professional competence, or the availability of specific interventions, or the physical characteristics of the treatment setting), and
- (b) The perception of the patient that the care received has been tailored to his or her own problems.

Part 2



CURRENT STUDY

1. Structure

Characterizing the Structure of a Psychiatric Department ought to include both the available human resources as well as the structure/physical resources, and the specificities of the components.

1.1. Psychiatric Department

The Psychiatric Department is composed of four Functional Units and a Child and Adolescent Psychiatry Team (Cardoso & Ferreira, 2012)

At all times, the Department has a number of psychiatric and GP residents, as well as medical students, trainees and interns connected to the other mental health professionals in the department.

1.1.1. Acute Inpatient Functional Unit

This Unit has a capacity of 29 beds for patients in acute phase and/or patients who need Electro-convulsive Therapy (ECT), whichever their pathology. The only exceptions are patients with alcohol or drug abuse/addiction as primary diagnoses, and no psychiatric comorbidity .

The team is composed of 16 Nurses, 4 Psychiatrists, 7 hospital orderlies, 1 Occupational Therapist and 1 secretary.

1.1.2. Community Functional Unit

Four (CMHT) Community Mental Health Teams (three of which are located in Primary health care centres in three Parishes in the Municipality of Amadora: Amadora, Damaia, Brandoa, and a fourth located in the Municipality of Sintra, namely in the Parish of Massamá. The latter mental health team has independent installations located in the community.

This unit offers:

- 1) Interventions based on each patient's specific needs,
- 2) Accessibility and close contact with the severe mentally ill patients,
- 3) Early pedagogic or rehabilitative interventions,
- 4) Social inclusion of the patients, working with the families and with community structures,
- 5) Articulation with Primary Health Care,
- 6) Cooperation with community structures (Amadora and Sintra Municipalities and NGOs).

The teams provide psychiatry and psychology consultations, they control and administer both oral medication and depot medication, psychological, social and nursing evaluations of the patients, individual, family and group psychotherapies as well as social interventions. On a regular basis, the teams have meetings with the local GPs, given that the articulation with these professionals is fundamental. These meetings are the perfect opportunity to present and discuss clinical cases, to refer and back-refer patients, and to offer training and formation sessions on predetermined subjects.

Each team is composed of: 2 psychiatrists, 2 nurses, a social worker, a clinical psychologist and a secretary, with the exception of the team located in Massamá, which has one more psychiatrist (since September 2012), a security guard and a cleaning employee.

The Department has also created two day-centres in the community (*espaço@com* – *space@com*), one located in Damaia, one of the primary health care centres and the other in the Massamá mental health team facility. These day-centres are a means to accompany severe mentally ill patients in the community. The teams in the Psychiatric Department refer patients, when the patients need therapeutic interventions aimed at maintaining or promoting autonomy, functional rehabilitation and socio-occupational (re)integration.

The objective of the day-centre is to integrate, in the same space, new activities and enhance the existing ones already being undertaken by the community teams, such as evaluation and treatment activities, psychosocial interventions and rehabilitation techniques. The other objective is to promote the development of these activities, in order to offer solutions that are more adequate for the patients' and their families' needs.

Each of the teams is composed of an occupational therapist and a psychomotor therapist, who receive support from a psychiatrist.

1.1.3. Day Hospital Functional Unit

The Day Hospital has a capacity for 25 patients in a regimen of partial-admission. It provides individual and group, therapeutic and creative activities.

Patients are referred to the Day Hospital by their assistant psychiatrist, whether from the inpatient unit, the community team or the liaison psychiatry team. Each patient has an intensive, coordinated and structured individualized therapeutic plan, which is also flexible and corresponds to the patients' evolutive needs. This plan defines the activities in which the patient will participate, and is revised by the team on a weekly basis.

The length of stay is variable. However, the preconised period is between three to six months. All through the period of partial-admission the patient maintains regular contact with his/her assistant psychiatrist, and after discharge returns to the respective community team. The therapeutic activities offered by the Day Hospital are:

- Two different weekly group psychotherapy activities;

- Multifamily analytic psychotherapy;
- Social skills training;
- Physical activities in both an exercise room and a swimming pool;
- Cognitive remediation and rehabilitation therapies;
- Domestic management/ management of the therapeutic “bar”/ and a monthly “restaurant”;
- Socio-recreational activities;
- Weekly and week-end programming activities, and
- A quarterly newspaper elaborated by the patients.

The Day Hospital, in collaboration with the inpatient unit, also includes a Psychoeducational activity for patients suffering from Bipolar disorder and their families (*Porta Aberta* – Open Door). The latter begins in the Day Hospital while the patient is still an inpatient.

The team of the Day Hospital is composed of a psychiatrist, a clinical psychologist, two occupational therapists and a nurse specialized in mental health.

1.1.4. Liaison Psychiatry Functional Unit,

This Unit renders psychiatric and psychological care to patients admitted to other medical departments of the Hospital, or patients who are in specialized medical outpatient care, and who have mental health problems associated to their somatic disorders. This team’s catchment area is that of the Hospital, and not only that of the Psychiatric Department, which means that they get referrals of patients living in the Sintra and Amadora Municipalities.

The team is composed of three psychiatrists and a clinical psychologist.

1.1.5. Child and Adolescent Mental Health Team

Although the geographical area of the hospital is of the responsibility of the Child and Adolescent Psychiatric Department of the Hospital Dona

Estefânia, the Psychiatric Department of the HFF created a small Child and Adolescent Psychiatry team to improve accessibility.

This team is composed of two child psychiatrists, a clinical psychologist, and the partial support (20%) of one of the Department's psychomotor therapists. Despite the fact that this team operates in the Hospital, it has considerable articulation with structures in the community, and within the hospital, namely with the paediatric department.

1.1.6. Psychiatric Emergency

The Psychiatric emergency functions 7 days a week, from 8:00 am to 00:00 am, and is located in the Hospital's General Emergency Service. The Department's psychiatrists, who are scheduled according to a monthly roster, maintain the psychiatric emergency. After midnight, the psychiatrists are not physically present but they remain on-call until 8:00 am the next day.

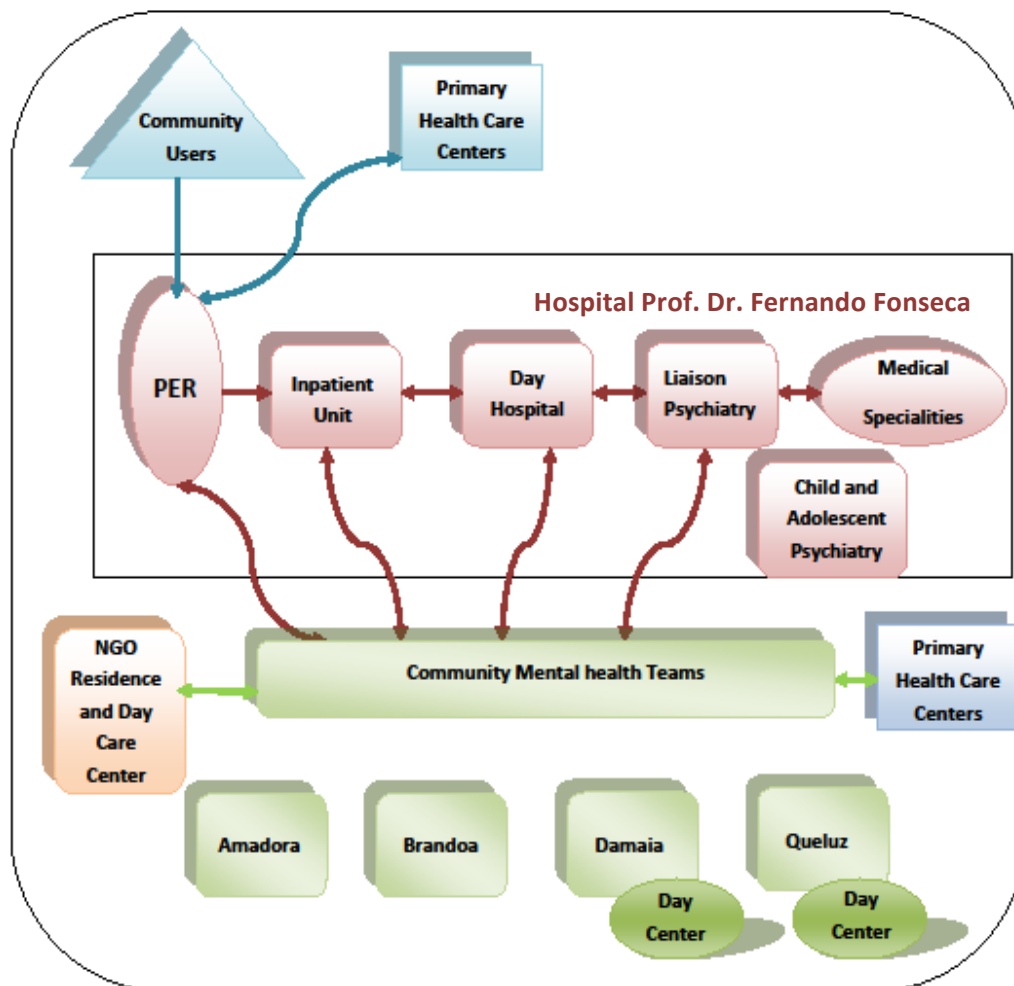
1.1.7. Recomeço

In 2000, facing the great lack of rehabilitation structures in the community for mental health patients, the professionals working in the Psychiatric Department created an NGO named **Recomeço** – Associação para a Reabilitação e Integração Social Amadora/Sintra (which means: *New Beginning* – Association for Rehabilitation and Social Integration Amadora/Sintra). The NGO is funded by the Ministry of Solidarity and Social Security. The foundation of this NGO was based on the need to create alternative solutions for the patients, namely a day-centre, with capacity for 30 patients, and a Protected/Assisted-living residence, which is a residential treatment facility for persons with chronic mental illness, and has a capacity for seven patients.

The NGO operates in installations granted by the Amadora Municipality, with whom there is close articulation in a number of projects. Although the NGO is not "officially" part of the Department, the professionals that work there

participate in various formation and training activities held in the Department, and maintain close articulation with the community teams responsible for the patients that are referred to the NGO.

FIGURE 2 - FLOWCHART - PATIENT REFERRAL AND BACK-REFERRAL TO AND FROM THE PSYCHIATRIC DEPARTMENT AND THE PER



1.2. Population

The first mental health Portuguese epidemiological study of the population was carried out in 2008-09 by the Department of Mental Health, Faculty of Medical Sciences, New University of Lisbon, and resulted from an international consortium lead by the WHO and the University of Harvard. The survey revealed that almost 23% of the population suffered from a mental health problem in the 12 months preceding the study interviews.

The most common psychiatric disorders found were anxiety (16.5%) and depression (7.9%), in addition to “impulse control disorders” (3.5%), and alcohol and drug abuse and addiction (1.6%). In terms of depression, “major” depression had a prevalence of 6.8%. This study showed an overall prevalence of severe mental illness of 6,3%, whereas the world “leader”, the United States of America has a prevalence of 7.7%.

The principal researcher of this study in Portugal, Prof. José Caldas de Almeida, highlighted the fact that, approximately 33.6% of all severe cases received no treatment for their mental health problem, and added that these cases should receive specialized mental health care. In line with these findings, merely 35% of people suffering from depression received care during the year of onset, and the median between onset of first depressive symptoms and actual treatment was five years. In the cases of panic disorders, the median was two years, however, approximately only one-half of all cases had contact with clinical services. According to Prof. Caldas de Almeida, life-time prevalence of mental health problems was very significant, at 42.7%.

This study also revealed the following risk factors for developing a mental health problem: female gender, age group between 18 and 24 years, marital status (estranged, widow and divorced), and people with low to moderate levels of literacy (Caldas de Almeida & Xavier, 2013).

These results are very important, because they reflect the “health of the Nation”, which is a cause for great concern. Nonetheless, is the fact that in the catchment area of the Hospital Prof. Dr. Fernando Fonseca, the considerable number of immigrants, approximately 10.1% (vs. country average of approximately 5% of the population) holds a further challenge to the health professionals working in this area.

According to provisional data of the 2011 National Census provided by the INE (National Institute of Statistics), the population of the Hospital’s catchment area is 552.972 persons living in the Amadora and Sintra Municipalities.

However, the Psychiatric Department has a smaller catchment area than the Hospital as, only the population residing in the Municipality of Amadora and

five parishes of the Municipality of Sintra, that border the Municipality of Amadora, belong to the Department's catchment area. This means that the population living in this smaller catchment area may be characterized as follows:

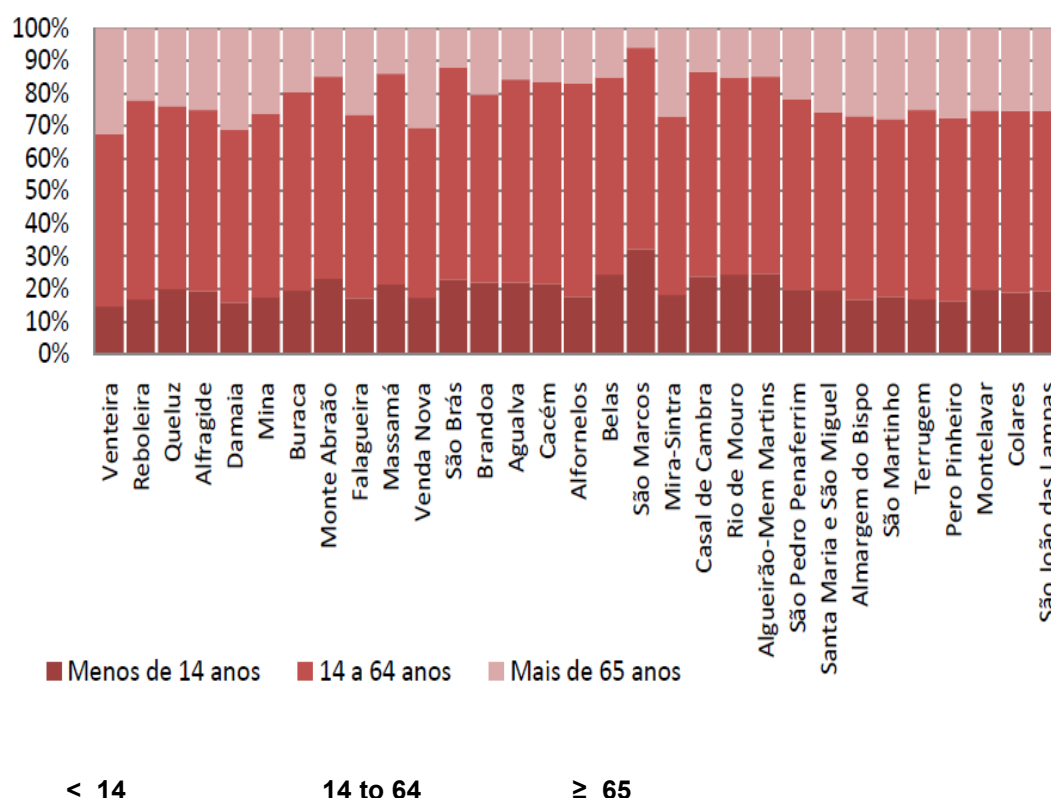
TABLE 1 - POPULATION RESIDING IN THE PSYCHIATRIC DEPARTMENT'S CATCHMENT AREA, CHARACTERIZED BY GENDER AND NO. OF FAMILIES (SOURCE INE 2011)

Municipality		Population	Male	Female	% Male	% Female	N. of Families
Amadora		175.135	82.348	92.787	47,02%	52,98%	73.457
Sintra	Queluz	26.248	12.182	14.066	46,41%	53,59%	11.144
	Monte Abraão	20.809	9.804	11.005	47,11%	52,89%	8.305
	Massamá	28.112	13.390	14.722	47,63%	52,37%	10.692
	Belas	26.089	12.689	13.400	48,64%	51,36%	9.138
	Casal de Cambra	12.701	6.168	5.533	48,56%	51,44%	4.530
TOTAL		289.094	136.581	151.513	47,56%	52,44%	117.266

The Hospital Prof. Dr. Fernando Fonseca, in collaboration with ImproveConsult, a research and consultancy firm, performed a study, presented in April 2011, based on the epidemiological characterization and accessibility of the population to medical care in the Hospital's catchment area.

Besides gender, this study presented two further characteristics that were significant, namely the age groups and nationality of the population that have accessed the Hospital during the year 2008. In Graph 1, the population of the two Municipalities stratified by age.

GRAPH 1 - AGE GROUPS OF THE POPULATION RESIDING IN THE AMADORA AND SINTRA MUNICIPALITIES, BY PARISHES (SOURCE HFF'S INTRANET)



According to the study, there are 101 different nationalities represented, which has a weight of 10.1% of the total population, as pointed out previously. The vast majority, 74.8%, of the immigrants residing in these two Municipalities are from Angola, Cape Verde, Brazil, and Guinea-Bissau.

2. Process

Subsequently, the process of care delivered by the Psychiatric Department will be described, both quantitatively and qualitatively. For the quantitative description, data received from the Psychiatric Department's Director and from the Hospital's Production Department will be presented. This data refers to the period of January 2008 to July 2011, the period chosen to describe the care process. Although the study sample is composed of all the patients admitted for the first-time in the course of 2008 to 2010, the additional 7 month period corresponds to patient follow-up in the Department.

The data concerning the first 7 months of 2011 are estimates based on the years' totals, with the exception of the data referring to the psychiatric consultations in the Community and the Liaison Psychiatry Units, and the number of sessions in the Day Hospital, which are exact. In the few exceptions where data was not available, the missing data was extrapolated, based on the previous and/or subsequent years' totals. The qualitative description will be based on various annual reports of the Department's activity, and on the in-depth knowledge of the study's author, who has worked for almost seven years in a community team, and for over nine years in the Day Hospital.

2.1. Acute Inpatient Functional Unit

The inpatient ward of this Psychiatric Department admits patients from the age of 16, and as it has a limited amount of beds (29) for the whole catchment area of almost 300 000 habitants, only patients with severe mental illness are admitted.

Patients with primary alcohol or substance abuse diagnoses are not admitted to the Psychiatric Department, but are referred to specialized institutions. However, patients that have acute psychopathology with associated substance abuse, as a secondary diagnosis, are in fact admitted. According to the Mental Health Policy Implementation Guide, (Department of Health, U.K., 2002) supporting someone with a mental health illness and substance abuse problems is one of the biggest challenges facing frontline mental health services. The complexity of issues makes diagnosis, care and treatment more difficult, with service users being at higher risk of relapse, readmission to hospital and suicide.

TABLE 2 – THE IN-PATIENT UNIT: PATIENT OCCUPANCY, LOS, FIRST ADMISSIONS AND COMPULSIVE ADMISSIONS BETWEEN 2008 AND 2011

	2008	2009	2010	2011
Patients Discharged	557	531	429	427
Occupancy Rate	87.9%	85.4%	88.6%	89.7%
LOS in days	16.8	17.0	20.3*	20.1*
1st. Admissions	193	177	173	**
	34.6%	33.3%	40.3%	
Compulsive Admissions	60	52	48	44
	10.8%❖	9.8%❖	10%❖	10.3%**
Compulsive 1st. Admissions	40	32		**
	7.2%❖	6.0%❖	34	
	66,7% ❖	61.5% ❖	7.9%❖	
			70.8% ❖	

* The length of stay increased between 2009 and the following years due to long-term admissions of several chronic psychotic patients.

** These admissions were not included in the present study.

❖ Percentage of compulsive admissions compared to total number of admissions in each year

❖ Percentage of Compulsive 1st. Admissions compared to total number of Compulsive admissions.

In the Psychiatric Department of the HFF, during the course of admission, the patient is introduced to her/his key community psychiatric nurse, and once a week, on Wednesdays, the community teams meet with the teams' psychiatrists who work in the inpatient ward to discuss the patients and plan their discharge. At discharge, the patients are routinely given the address and telephone number of the location (primary health care centre or mental health centre) where they will have their appointment, along with their prescription and time and date of the appointment. As a rule, the appointment is scheduled for a date no later than 15 days after discharge.

Besides the various meetings held between the inpatient/community units, the Day Hospital/community units, the Day Centres/community units, and the NGO-Recomeço/community units, other meetings also take place on Wednesdays, namely clinical sessions, Journal club, and supervisory meetings held with the Departments' psychiatry residents.

All of these meetings are essential in order to maintain continuous care of the patients, and enable continuous training and formation for all of the Departments' professionals.

2.2. Community Functional Unit

Once the patients are referred, the Community Mental Health (CMH) Nurses triage the patients according to severity, and a first psychiatric consultation is scheduled.

TABLE 3 - NUMBER OF FIRST AND FOLLOW-UP PSYCHIATRIC CONSULTATIONS IN THE COMMUNITY MENTAL HEALTH UNIT BETWEEN 2008 AND THE 31ST JULY 2011

Psychiatrists	2008	2009	2010	Until the 31 st July 2011*
1 st . Consultations	803	800	787	537*
Follow-up Consultations	13.523	14.294	14.184	7.906*
Total	14.326	15.094	14.971	8.443*

* Data provided by the Productions Department of the HFF

Over the years of clinical activity, the numbers of first and follow-up consultations have stabilized.

In table 4, it is evident that there are differences in the number of Triage sessions and first psychiatric consultations. This difference is due to different register methods, which has since been corrected at the service level.

TABLE 4 - COMMUNITY MENTAL HEALTH NURSING ACTIVITY BETWEEN 2008 AND THE 31ST JULY 2011

Nurses	2008	2009	2010	Until the 31 st July 2011*
Triage	463	525	502	362
Follow-up	1.209	1.237	2.068	995
Family Intervention	465	380	517	346
Depot	5.568	6.245	6.704	3.827
Pulse / Temperature	64	71	37	60
Blood Pressure	169	161	375	179
Oral Medication	817	1.369	1.411	542
Contacts	2.598	3.541	4.402	2.790

* Estimates based on the year's totals

As Table 4 shows, besides usual nursing techniques, the CMH nurses play an active role with both patients and their families, as well as stimulate and facilitate medication compliance, especially with chronic patients who need support in controlling their daily oral medication.

Referral to the psychologists in the CMHT is only undertaken after a first assessment of the patient by the psychiatrist. Therefore, patients in the community do not have direct access to these professionals. This form of triage enables access of those in need and those whom may benefit from a psychotherapeutic intervention.

Besides the psychotherapeutic interventions, psychologists also perform personality, cognitive, psychopathological and behavioural assessments (Table 5).

TABLE 5 - COMMUNITY PSYCHOLOGY ACTIVITY BETWEEN 2008 AND THE 31ST JULY 2011.

Psychologists	2008	2009	2010	Until the 31 st July 2011*
Psych. Assessment	118	92	85	92
1 st . Consultations	114	105	92	85
Psychology Follow-up	1.008	759	1.176	616
Individual Psychotherapy	1.445	1.287	1.188	819
Group Psychotherapy*	365✱	270✱	203✱	122✱
Family Therapy	6	8	0	0

✱ Total number of participants in the Group Psychotherapy groups

* Estimates based on the year's totals.

The same rule of thumb goes for the CMHTs' social workers, who only work with patients who belong to the respective CMHT. Table 6 is indicative of the available social interventions.

TABLE 6 - ACTIVITY OF THE SOCIAL SERVICE BETWEEN 2008 AND THE 31ST JULY 2011

Social Workers	2008	2009	2010✱	Until the 31 st July 2011*
Social Assessment	153	160	61	91
Follow-up	1.376	1.508	366	855
Community Intervention	75	88	✱✱	39
Contacts users+families	377	776	98	220
Institutional Contacts	2.108	1.923	561	1.179
Social Report	122	210	57	105

✱ All of the data pertaining to 2010 is incomplete.

✱✱ Unavailable data

* Estimates based on the year's totals

Besides all the "individual" professional approaches, the CMHT also have conjoint activities in which two or more professionals intervene. These may be

home visits, conjoint individual or group sessions, or even contacts with facilities in the community.

2.3. Day Hospital Functional Unit

Either the CMHTs or the Inpatient Unit refers patients to the Day Hospital, but there have also been patients referred by the Liaison Psychiatry Unit. The patients, preferably with a family member, attend an initial admission meeting, with all of the professionals in the unit, whenever possible. This facilitates the discussion and elaboration of the patients' individual therapeutic projects.

TABLE 7 - AVERAGE NUMBER OF PATIENTS AND TOTAL NUMBER OF SESSIONS IN THE DAY HOSPITAL BETWEEN 2008 AND THE 31ST JULY 2011

	2008	2009	2010	Until the 31 st . July 2011
Average # patients	23.4	25.6	20.5	21.8
# of Sessions	5.269	6.492	5.904	3.608

2.4. Liaison Psychiatry Functional Unit

The professionals that constitute this Functional Unit attend patients that are admitted to medical and surgical departments of the general hospital, and frequently extend the care of these patients after medical discharge. Referrals to the Psychologist follow the same rule as used in the CMHTs. This team also has a very active role in delivering training and formation to all professional groups in the Hospital.

TABLE 8 - ACTIVITY OF THE LIAISON PSYCHIATRISTS BETWEEN 2008 AND THE 31ST OF JULY 2011

Psychiatrists		2008	2009	2010	Until the 31 st . July 2011*
Consultations	1 st	398	380	276	273
	Follow-up	2.076	2.184	2.176	1.314
Medical Departments	1 st	521	511	544	322
	Follow-up	478	531	434	221
Total		3.473	3.606	3.430	2.130

* Data provided by the Productions Department of the HFF

TABLE 9 - ACTIVITY OF THE LIAISON PSYCHOLOGIST BETWEEN 2008 AND 31ST JULY 2011

Psychologist	2008	2009	2010	Until the 31 st . July 2011*
1 st Consultations	76	115	90	49
Follow-up	611	965	1.044	621
Total	687	1.080	1.134	670

* Estimates based on the year's totals

PART 3



METHODOLOGY

1. Objectives and Expected Outcome

The general objective of the present study was to assess a comprehensive integrated Psychiatric Department, in Portugal, which uses an assertive outreach community approach.

Specific objectives were the following:

The **first objective** was to characterize the patients with severe mental illness, who were admitted to the inpatient ward for the first time during the study period.

The **second objective** was to analyze whether the Department's quality indicators were achieved.

- The first quality indicator was the attendance of a psychiatric appointment during the 15 days after discharge.
- The second quality indicator is related to re-admissions during the marker period of 15 days after discharge.

The **third objective** was to examine the impact of different variables on the length of stay (LOS).

The **fourth objective** was to identify the pitfalls in the care process in order to suggest improvements in the Psychiatric Department.

The **fifth objective** was to measure the patients' satisfaction with the process of care received during the follow-up period after discharge from the inpatient unit.

Finally, this study aimed at providing data and results to support further service planning, which can include closer articulation with Primary Health Care, creation of new rehabilitation units in the community, and the creation of specific health promotion or illness prevention programmes, to name but a few.

While this study is not intended to be a monitorization of the quality of the Department, quality becomes implicit through the analysis of the Department's Structure, Process of care, and Outcome, namely the patients' satisfaction with the care received, their compliance with the care offered, and the number of patients who abandon treatment.

Locker & Dunt (1978 *in* Ruggeri et al., 2003) suggest that, particularly in long-term care, "quality of care can become synonymous with quality of life and satisfaction with care an important component of life satisfaction". The cross-cultural stability of this association and its predominance over other associations tested offer the appealing perspective that improvements to patients' subjective quality of life can be achieved by providing adequate and individualized care (Ruggeri et al., 2003). This objective is fundamental in a dynamic Psychiatric Department, that, whenever a new need arises, creates the corresponding solution, whether it is a new intervention for a diagnostic group, or a new form to register patients' activities.

2. Study Hypotheses / Inferences

The literature published on the subject of first admissions usually focuses on a specific diagnostic category namely Schizophrenia or Bipolar Disorder, when characterizing patients, psychiatric Departments and interventions. The setting of the current study admits all patients with severe mental illnesses, which on one hand is very enriching, due to the variability, but on the other hand, it is more challenging in the process of constructing hypotheses. A

further central factor is that one of the main objectives of this research is precisely the socio-demographic characterization of the patients that are admitted for the first time, which has more of a descriptive nature, and which makes the task of constructing hypotheses a much more arduous one, since studies published with similar characteristics to this one, are scarce and there is not always consensus among them. Nonetheless, the following hypotheses / inferences were formulated:

H0 – There are no differences in satisfaction with health care between patients that use the available ambulatory services after discharge from the inpatient unit and those who do not use the available services.

H1 – There is a difference in satisfaction with health care, between patients that use the available ambulatory services after discharge from the inpatient unit and those who do not use the available services.

H2 – There is a difference in the care process (number of interventions in the community mental health team) between patients with dual diagnoses and those who do not have dual diagnoses.

H3 – There is a difference in the care received before first time admission between non-Caucasian and Caucasian patients.

H4 – There is a difference in psychopathology in patients of non-Caucasian and Caucasian origin, measured by longer length of stay during first admission

H5 – There is a difference in the length of stay between patients that have compulsory admissions and those who do not have compulsory admissions.

H6 – There is a difference in length of stay between patients that have risk behaviour and those who do not have risk behaviour.

H7 – There are differences in satisfaction between patients with different groups of diagnosis

3. Variables

3.1. Predictor Variables:

- Sociodemographic variables
Sex; Age; Ethnic origin; Education level; Employment status; Living situation (homeless, family home, etc.); Marital status;
- Service Use: PER visits; admissions; outpatient care; day hospital sessions; Liaison psychiatry.
- Previous psychiatric/psychological attendance in the CMHT and/or the Liaison psychiatry team;
- Psychiatric Diagnoses;
- Dual Diagnoses (alcohol and substance abuse);
- Compulsory admission;
- Risk Factors / behaviour (suicide, self-harm, violence towards others and absconding from the inpatient unit);
- Physical restraint during admission

3.2. Outcome Variables:

- Satisfaction with Health Care Service.
- Readmission during the period of 15 days after discharge.
- Attendance of first psychiatric appointment in the 15 day period after discharge.

4. Methodology

4.1. Study Design

To attain the proposed objectives a retrospective cohort design was chosen as the most appropriate.

4.2. Population

The sample is composed of all the patients admitted for the first-time to the inpatient ward of the Hospital Fernando Fonseca's Psychiatric Department (n=543) between 2008 and 2010 and then followed-up until the 31st. of July of 2011. The referral may have various sources, namely: other medical departments in the Hospital, self-referral through emergency room, community mental health teams, day hospital, or referrals from private practice. There were no exclusion criteria used in the process of composition of the study sample.

4.3. Procedures

For the analysis of the patients' care process, data was mainly obtained from the Hospital data bases, namely the "Admissão" database, and from reviewing the patients' paper-based clinical records.

The "Admissão" data base contains all of the information concerning the care process, and all of the relevant information was registered. The information includes the following:

- the number of visits to the psychiatric emergency unit before and after the first admission,
- Length of stay - LOS,
- the number of psychiatric and psychological appointments attended,
- the number of re-hospitalizations, and whether these occurred in a period of 15 days after discharge, or not,
- the number of contacts with the psychiatric nurses (including for the administration of depot anti-psychotics and assistance in the taking of oral medication),
- the number of contacts with the social workers,
- if patients received home visits by the mental health team during the follow-up period, and
- if they were referred to the Day Hospital or Day Centres.

Other aspects considered were, namely if these patients abandoned the Community Psychiatric Care, if they chose treatment in private practices, and if

they were referred elsewhere namely Substance abuse treatment centres, or other medical specialities.

A second data base was used, and adapted for this study. The original data base contained the following variables: Name; No. of Hospital registration; Date of admission; Date of discharge; Provenience; Date of Birth; Gender; Ethnicity; Area of Residence / Community Mental Health Team; No. of admissions; ECT; Compulsory admission; Name of the assistant Psychiatrist; and the type of Discharge. When the patients are discharged from the inpatient ward, the ward's secretary adds the patients' information to this basic database. The author of the study had access to this database and added further variables, which will support a more thorough characterization and analysis of the first-time admissions.

The next step was the requisition of all of the patients', paper-based, clinical records, with the purpose of completing the information on the current study database. The majority of the necessary information is located in the questionnaire (AIESMP – *Avaliação Inicial de Enfermagem em Saúde Mental e Psiquiátrica* – Initial Nurse Assessment in Mental Health and Psychiatry)(Annex 1).

During the period of analysis of the patients' clinical records, the Hospital's "Admissão" database was accessed, to collect all of the interventions that the patients have received during the follow up period. This information was then also added to the study database. To access the "Admissão" database the principal investigator had to request a user's name and password, which was readily provided. The information obtained in this database is of utmost importance, since it reflects the **Process** of care that the patients have received.

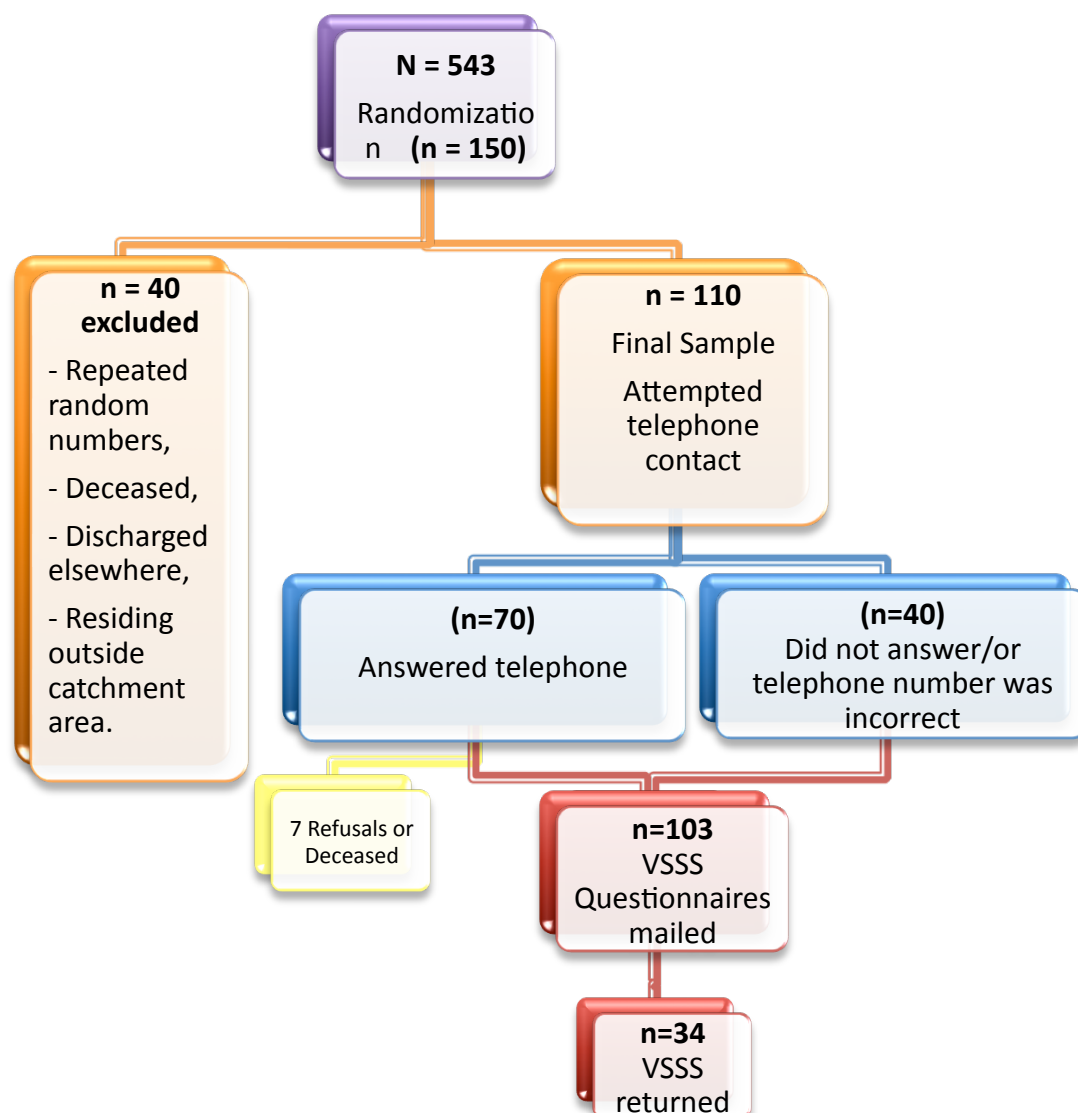
The next step, and in order to complete the data on the patients that had apparently interrupted their care process, and to determine the reasons that lead to this discontinuation, a list of the patients was provided to their respective community teams.

Finally, to assess the main Outcome, a sample of randomly selected patients was contacted with the objective of participating in the study, namely for the administration of the Verona Service Satisfaction Scale (VSSS).

This phase was initiated with recourse to a randomization table, and a list containing 150 random numbers was generated. These numbers corresponded to the order of admission during the 3-year period. Flowchart 2 is a summary description of the procedure.

Several attempts were made to contact the patients by telephone, however only 34 patients completed and returned the questionnaires, which corresponds to a response rate of 33.3%.

FIGURE 3 - FLOWCHART – STEPS UNDERTAKEN TO ASSESS PATIENTS’ SATISFACTION WITH CARE RECEIVED.



According to Killaspy et al. (2000) recruitment (especially of the who dropped out) is a particular problem when investigating those who by definition have defaulted from their treatment plan. Therefore, in their study, as in this research, an attempt was made to contact as many of the selected subjects as possible to minimise non-response bias.

Ruggeri (1994) stated that “response rates in satisfaction studies are usually low, even though they vary slightly according to the method used. Many studies of client satisfaction done utilizing mailed questionnaires have achieved very low response rates of between 30% and 40%. (...) Those methods that yield the highest rate of return, are more costly, both in money and personnel time, and can be biased by undifferentiated high satisfaction ratings if confidentiality is not carefully pursued”.

4.4. Selection of Instruments

The instruments that were selected for the study are the following:

4.4.1. The AIESMP - *Avaliação Inicial de Enfermagem em Saúde Mental e Psiquiatria* (Initial Nurses' Assessment in Mental Health and Psychiatry)

It is routinely used in the Psychiatric Department's inpatient ward. In the period of 48 hours after the patients are admitted, the ward nurse that is responsible for the patient, during an interview with the patient, completes a questionnaire (AIESMP) that collects the following data: Sociodemographic, Health status, Psychic assessment, Somatic assessment, which includes substance and alcohol abuse, and Social assessment. This instrument was created in the Psychiatric department, and adapted according to the Quality Accreditation board's specifications in May of 2009. One of the questions contained in this instrument is whether the patient has been previously admitted to the in-patient ward and whether the admission is compulsory or not.

4.4.2. WHO - International Classification of Mental Health Care (ICMHC) (Annex 2)

In order to assess the Structure of the Psychiatric Department, the author used the International Classification of Mental Health Care (WHO - ICMHC). The World Health Organization – Collaborating Centre was contacted for information on the existence of a Portuguese version, and in the absence of this version, permission was granted by WHO for the translation of the instrument to the Portuguese language.

The ICMHC was translated to Portuguese by the author of this study, whose native language is English, who has been living in Portugal for over 30 years, and who has had significant experience in translating and back-translating technical documents, and other assessment instruments, on subjects such as Psychiatry, and Psychotherapy⁸.

The ICMHC systematically describes the interventions actually provided by the mental health services. Subsequent versions of the original ICMHC produced by Jong, A. (1996), were developed, using comments from experts in 24 WHO field centres and results from a number of field trials.

The Final version includes 10 Modalities of Care to describe Modules of Care (or Functional Units), using the Level of Specialization scale. According to Jong (1996) "it was recommended that the ICMHC should consist of two parts; one dedicated to the classification of "curative activities" (Psychiatric Care), the other to "rehabilitative activities" (Psychosocial Rehabilitation). The same design and methodology should be used for both parts of the classification". The Italian research team, using data from 43 services, evaluated the inter-rater

8 - The Portuguese version was then sent to a Portuguese Psychiatrist, who is also bilingual, with the objective of correcting the Portuguese version. The retroversion or back-translation will be accomplished in the near future with the objective of validating the Portuguese version. Once translated back to English, this will be compared to the original version of the ICMHC. The intention is to request the aid of the author of the instrument to participate in this validation process. The validation of the Portuguese version of the ICMHC goes beyond the scope of this study.

reliability of this version and the results show that reliability ranged from excellent for nine modalities to reasonably good for the remaining modality.

In the context of evaluation studies, the ICMHC can be used to systematically describe mental health care interventions in different European countries. The modalities of care included are:

- 1 - Establishing and maintaining professional relationships;
- 2 - Problem and functional assessment;
- 3 - Care co-ordination;
- 4 - General health care;
- 5 - Taking over activities of daily living;
- 6 - Psychopharmacological and other somatic interventions;
- 7 - Psychological interventions;
- 8 - (Re)educating basic interpersonal and social skills;
- 9 - Interventions related to daily activities, and
- 10 - Interventions aimed at family, relatives and others.

The level of specialisation can be used to describe the modalities in greater detail. A rating scale was developed, the Level of Specialisation Scale (LoS-scale) that allows for the assessment of each Module of Care, on all of the ten modalities, with respect to this level. The LoS-scale is a four-point rating scale. The anchor points are labelled as follows: 3 = High level of specialisation; 2 = Intermediate level of specialisation; 1 = Low level of specialisation and; 0 = Not applicable to this Module/Functional Unit of Care. Since the ten modalities of care are aimed at (occasionally) very different aspects of the process of providing care, it is not possible to have a set of generally applicable criteria to determine the level of specialisation. For this reason, examples for the different levels of the LoS-scale are given for each modality.

The first step in any application of the ICMHC is the identification of the Modules/Functional Units of Care to be classified. If the ICMHC is used to describe all or some of the services providing care to a specific catchment area, it is recommended to start with drawing up a list of these services and use this

list as the basis for the identification of the Functional Unit of Care. It is recommended to base the identification of the Functional Unit of Care on the organisational structure of the mental health care service or system under consideration. In principle, any part of a mental health care service or system is a Functional Unit of Care; inpatient and outpatient services as well as services for day treatment. Forms of collaboration between two or more mental health care services, aimed at providing care to a circumscribed group of patients may also qualify as Modules/Functional Units of Care. In general, a rule of thumb for the procedure of identifying Modules/Functional Units is that these should have some kind of administrative reality. In other words, be identifiable in the records (financial, administrative or otherwise) of the relevant mental health care services.

Once identified, the Modules/Functional Unit of Care will have to be classified. This should preferably be done by assessors, meeting the following criteria:

1. They should be well acquainted with the ICMHC, its background, purpose and procedures,
2. They should be well acquainted with the theory and particularly with the everyday practice of the process of providing mental health care, and
3. They should have a good overview of the mental health care services under consideration and of the different forms of collaboration between these services.

Assessors should visit all Modules to be classified and interview staff members to obtain the information needed to classify the module. If a description of the objectives of care of the Module and the population served is available, it is recommended to use this document as the main source of information and as a guideline during the interview. It should be remembered, that all assessments pertain to the month preceding the moment of classification and to interventions that could actually be applied in that period. Classifications should be made by the assessors based on all information available to them.

Once a Module/Functional Unit of Care has been assessed on all of the ten modalities it is possible to construct a Profile of Care, which describes the Functional Unit or the various Units within a Service or Department.

4.4.3. Verona Service Satisfaction Scale (VSSS) (Annex 3)

The VSSS (Ruggeri et al., 2000), is a self-administered instrument, which consists of 54 items, which conceptually comprise seven domains, and that is used to assess satisfaction with services. In brief, the domains are:

- Global or overall satisfaction dimension consists of three items which cover general aspects of satisfaction with psychiatric services;
- The professionals' Skills and Behaviour dimension consists of 24 items, which cover various aspects of satisfaction with the professionals' behaviour, such as technical skills, interpersonal skills, cooperation between service providers, respect of patients' rights, etc. Psychiatrists, psychologists, nurses and social workers are assessed in separate items;
- The Information dimension consists of three items which cover aspects related to satisfaction with information on services, disorders and therapies;
- The Access dimension consists of two items which cover aspects related to satisfaction with service location, physical layout and costs;
- The Efficacy dimension consists of eight items which cover aspects related to satisfaction with overall efficacy of the service, and service efficacy on specific aspects such as symptoms, social skills and family relationships;
- The Types of Intervention dimension consists of 17 items which cover various aspects of satisfaction with care, such as drug prescription, response to emergency, psychotherapy, rehabilitation, domiciliary care, admission, housing, recreational activities, work, benefits, etc;
- The Relatives' Involvement dimensions consists of six items which cover various aspects of the patients' satisfaction with help given to his/her closest relative, such as listening, understanding, advice, information, help coping with the patients' problems, etc.

In cases of cognitive deficit, severe psychopathology or low level of literacy, the patients may be assisted by having the items read through with them. According to Ruggeri et al. (2000, 2003, 2007), the VSSS was designed for use in comparative cross-national research projects as well as in routine clinical

practice in mental health services across Europe and has been shown to have good levels of internal consistency and test-retest reliability. A Portuguese translation of this scale was carried out by Xavier & Caldas de Almeida (Xavier, 1999). One of the authors of the Portuguese translation was contacted in order to request authorization for the use of this scale in the current study, and which was promptly granted.

Ruggeri et al. (2007) describe this instrument as being designed for self-administration and can be completed without prior training in 20-30 minutes. The subjects are asked to give overall rating about their experience of the mental health services they have been attending / or attended in the previous year. For items 1-40, satisfaction ratings are on a 5-point Likert scale (1, terrible; 2, mostly unsatisfactory; 3, mixed; 4, mostly satisfactory; 5, excellent). The items are presented with alternate directionality to reduce stereotypic responses. Items 41-54 consist of three questions each: First, the subject is asked if he/she has received the specific intervention (Question A: "Did you receive the intervention x in the last year?"). If the answer is 'yes', he/she is asked his/her satisfaction on a 5-point Likert scale, as above (Question B). If the answer is 'no', he/she is asked Question C: "Do you think you would have liked to receive intervention x ?" (6, no; 7, do not know; 8, yes). These questions allow measurement of the subjects' satisfaction both with interventions provided and with the professionals' decision not to provide an intervention. The latter may be considered a measure of under-provision from the patients' point of view. In the final section of the VSSS, two open-ended questions ask the subjects to state 'the thing I liked most is...', and 'the thing I disliked most is...'. Patients are considered dissatisfied when their mean scores were below 3.5 (Ruggeri et al., 2003).

In the Portuguese translation, the authors have translated point 3 of the 5-point Likert scale as 'reasonable/moderate'. Consequently, in the current study, scoring 3 or more was considered positive, accordingly, the patients were satisfied with the care received.

4.5. Statistical Analysis Plan

The first step of the statistical analysis will be a descriptive analysis of the sample, using descriptive statistics (distribution, central tendency and the dispersion).

The second step will be comparing subgroups of patients in the sample. For this, we will use the T Student test or Mann-Whitney for quantitative variables, as well as the Chi-square and Fishers Exact Test for qualitative variables.

4.6. Ethical Considerations and Approval

Permission requested from both the Hospitals' ethical and scientific committees to undergo the study in the Hospital, was duly granted on all levels.

All the patients included in the random sample or their representative, signed a written informed consent (Annex 4). Whenever the patients had any impairment, but were able to understand the questions in the questionnaire, or whenever there were low literacy levels, an attempt was made to contact a family member to aid in the completion of the questionnaire and the informed consent document.

Since this study is a retrospective descriptive study, and in no way will there be any changes in the patients' treatment or any other kind of experimental intervention, there are no other ethical issues to be considered.

PART 4

❧

RESULTS

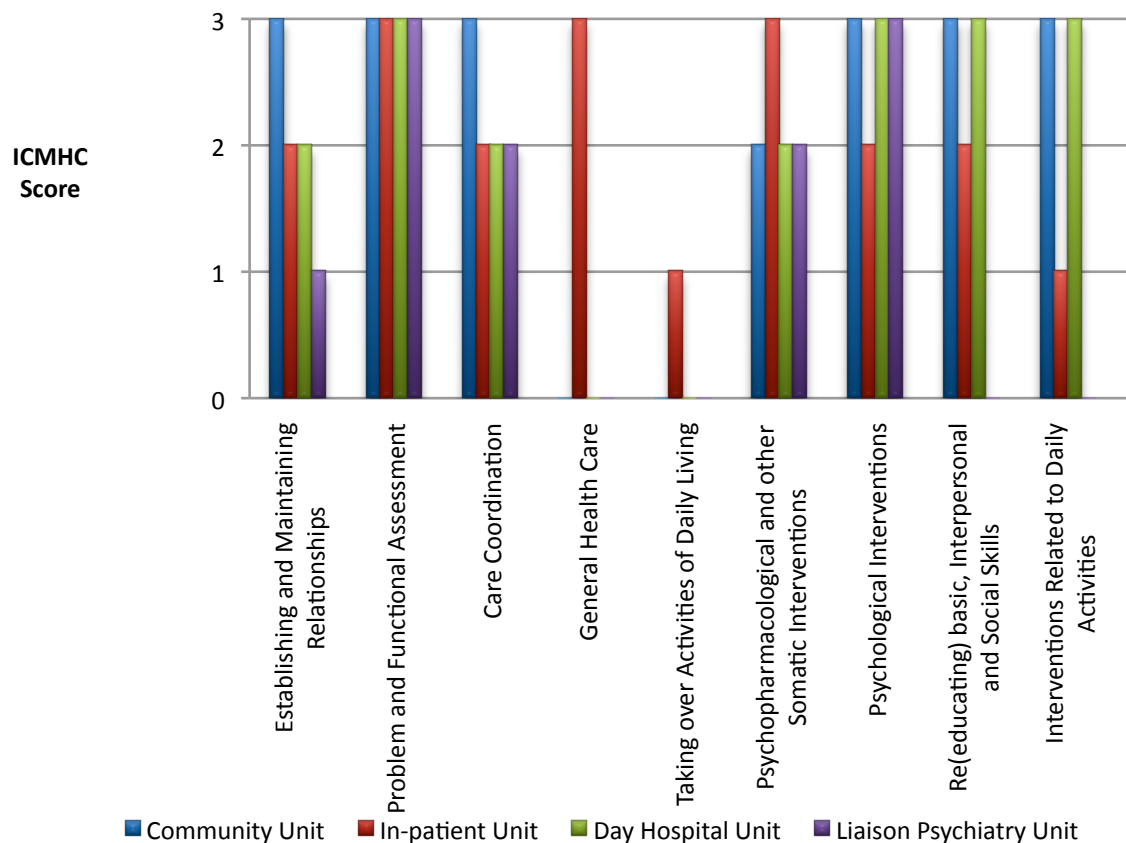
1. Results

1.1. Structure

1.1.1. Assessment of the Psychiatric Department

The Psychiatric Department and its Functional Units characteristics assessed with the International Classification of Mental Health Care (ICMHC) are summarized in Graph 2.

GRAPH 2 – PROFILE OF CARE OF THE PSYCHIATRIC DEPARTMENTS' FUNCTIONAL UNITS ACCORDING TO THE ICMHC



When classifying each of the Functional Units, both Psychiatric Care and Psychosocial Rehabilitation were taken into account in each of the Care modalities. As would be expected not all modalities were practiced in each of the Functional Units. The Liaison Psychiatry Unit had a more active role in Psychiatric/Psychological care and less in Psychosocial Rehabilitation due to the specificities of that Unit. On the other hand, only the In-patient Unit achieved full classification in the modality of General Health Care, and was the only Unit that took over some of the Activities of daily living, as expected in this type of Unit.

1.1.2. Characterization of the First Admissions Sample

The study sample of 543 patients was composed of 234 male and 309 female patients, consecutively admitted for the first time to the Psychiatric Department between 2008 and 2010. No patients were excluded. Table 10 illustrates the sociodemographic characteristics of the sample.

During index-admission, the sample had a mean age of 45.1 years \pm 17.2 years, 430 (79.2%) patients were Caucasian, 205 (37.8%) married or cohabiting, 179 (33.0%) were single, 241 (44.4%) were living with their nuclear family, 160 (29.5%) with their family of origin, and 104 (19.2%) lived alone.

Regarding education, 245 (45.1%) had between 5 and 12 years of schooling, 55 (10.1%) had obtained a university degree or higher and 16 (2.9%) were illiterate.

Of all the patients, 175 (32.2%) were unemployed, 171 (31.5%) were employed, and 115 (21.2%) were retired, 193 (35.5%) referred economical difficulties and the person of reference, most mentioned was a “parent”, by 151 (27.8%) patients, followed by “spouse” by 136 (25.0%).

TABLE 10 - SOCIODEMOGRAPHIC CHARACTERISTICS OF INDEX-ADMITTED PATIENTS (N = 543)

Variable	N=543 (%)	Male n=234(%) (43.1%)	Female n=309(%) (56.9 %)
Age – mean (s)	45.1 (±17.2)	41.2 (±17.8)	48.0 (±16.3)
Age (groups in years)			
16-24	69 (12.7)	48 (20.5)	21 (6.8)
25-34	94 (17.3)	47 (20.1)	47 (15.2)
35-44	120 (22.1)	53 (22.6)	67 (21.7)
45-54	113 (20.8)	38 (16.2)	75 (24.3)
55-64	57 (10.5)	18 (7.7)	39 (12.6)
65-74	60 (11.0)	18 (7.7)	42 (13.6)
75-84	24 (4.4)	8 (3.4)	16 (5.2)
85-94	5 (0.9)	3 (1.3)	2 (0.6)
95-100	1 (0.2)	1 (0.4)	0 (0.0)
Ethnic group			
Caucasian	430 (79.2)	179 (76.5)	251 (81.2)
Non-Caucasian	113 (20.8)	55 (23.5)	58 (18.8)
Education (years)			
Illiterate	16 (2.9)	2 (1.1)	14 (6.0)
1 – 4	72 (13.3)	28 (14.8)	44 (18.8)
5 – 9	146 (26.9)	70 (37.0)	76 (32.5)
10 – 12	99 (18.2)	53 (28.0)	46 (19.7)
> 12	35 (6.4)	15 (7.9)	20 (8.5)
University or <	55 (10.1)	21 (11.1)	34 (14.5)
Occupational status			
Student	27 (5.0)	15 (6.8)	12 (4.1)
Unemployed	175 (32.2)	97 (43.9)	78 (26.9)
Employed	171 (31.5)	67 (30.3)	104 (35.9)
Retired	115 (21.2)	41 (18.6)	74 (25.5)
Sick leave	13 (2.4)	1 (0.5)	12 (4.1)
Home-maker	10 (1.8)	0 (0.0)	10 (3.4)

Variable		N=543 (%)	Male n=234(%) (43.1%)	Female n=309(%) (56.9 %)
Marital Status				
	Married/cohabiting	205 (37.8)	80 (35.2)	125 (42.8)
	Divorced/separated	91 (16.8)	27 (11.9)	64 (21.9)
	Single	179 (33.0)	114 (50.2)	65 (22.3)
	Widowed	44 (8.1)	6 (2.6)	38 (13.0)
Living Situation				
	Family of origin	160 (29.5)	105 (46.3)	55 (18.8)
	Nuclear family	241 (44.4)	78 (34.4)	163 (55.8)
	Friends	7 (1.3)	4 (1.8)	3 (1.0)
	Alone	104 (19.2)	34 (15.0)	70 (24.0)
	Institution/Home	3 (0.6)	3 (1.3)	0 (0.0)
	Homeless	4 (0.7)	3 (1.3)	1 (0.3)
Person of Reference				
	Parent	151 (27.8)	91 (40.1)	60 (20.3)
	Sibling	74 (13.6)	37 (16.3)	37 (12.5)
	Spouse	136 (25.0)	51 (22.5)	85 (28.7)
	Child	83 (15.3)	14 (6.2)	69 (23.3)
	Friend/others	65 (12.0)	26 (11.5)	39 (13.2)
	None	14 (2.6)	8 (3.5)	6 (2.0)
Economical difficulties				
	No	319 (58.7)	139 (62.3)	180 (62.3)
	Yes	193 (35.5)	84 (37.7)	109 (37.7)

1.1.3. Sociodemographic characteristics and Gender

Comparison between male and female patients (Table 10) shows that female patients were significantly older (48.0 vs. 41.2), (t -test = -4.604, $p < 0.001$), more frequently illiterate (6.0% vs. 1.1% - $\chi^2 = 12.438$, $p = 0.029$) and when considering the years of education up to the end of secondary school, had lower levels of education than the male patients. On the other hand, a higher percentage of female patients held a university degree or higher, in comparison to the male patients (14.5% vs. 11.1%).

The variable occupational status, demonstrated significant differences between the genders ($\chi^2 = 30.417$, $p < 0.001$). A significant higher percentage of male patients unemployed (43.9% vs. 26.9%), and students (6.8% vs. 4.1%). Further, female patients were more frequently retired (25.5% vs. 18.6%), on sick leave (4.1% vs. 0.5%), and homemakers (3.4% vs 0%) compared to male patients.

Marital status distribution, significantly differed between genders ($\chi^2 = 54.320$, $p < 0.001$). Female patients were more frequently married/cohabiting (42.8% vs. 35.2%), divorced/separated (21.9% vs. 11.9%), and widowed (13.0% vs. 2.6%) than male patients. In addition, more than half of the males in the sample were single (50.2% vs. 22.3%).

As for living situation, while 43.6% of the male patients were living with their family of origin, that happened only in 18.8% female patients. On the other hand, female patients were living more frequently with their nuclear families, i.e. with their spouse, spouse and children or children (55.8 vs. 34.4%), and a higher percentage lived alone (24.0 vs. 15.0%) compared to male patients. However, the differences between genders did not reach statistical significance ($\chi^2 = 54.930$, $p = \text{NS}$).

Regarding the person of reference mentioned at admission, there are also significant differences between the genders ($\chi^2 = 45.891$, $p < 0.001$). A higher percentage of male patients referred a parent as their person of reference (40.1 vs. 20.3%), or a sibling (16.3 vs. 12.5%), whereas female patients referred with greater frequency their spouse (28.7 vs. 22.5%), followed by their children (23.3 vs. 6.2%).

TABLE 11 – ASSOCIATION BETWEEN MARITAL STATUS AND LIVING SITUATION BY GENDER IN THE STUDY SAMPLE, N=517

N = 517		Family origin n (%)	Nuclear Family n (%)	Friends n (%)	Alone n (%)	Institution n (%)	Homeless n (%)
Gender	Marital status						
Male	Married/ Cohabiting	3 (3.8)	76 (95.0)	0 (0.0)	1 (1.3)	0 (0.0)	0 (0.0)
	Divorced/ Separated	14 (51)	1 (3.7)	1 (3.7)	9 (33.3)	1 (3.7)	1 (3.7)
	Single	88 (77.2)	0	3 (2.6)	19 (16.7)	2 (1.8)	2 (1.8)
	Widowed	0 (0.0)	1 (16.7)	0 (0.0)	5 (83.3)	0 (0.0)	0 (0.0)
Female	Married/ Cohabiting	1 (0.8)	121 (96.8)	1 (0.8)	2 (1.6)	0 (0.0)	0 (0.0)
	Divorced/ Separated	8 (12.5)	27 (42.2)	2 (3.1)	27 (42.2)	0 (0.0)	0 (0.0)
	Single	44 (68.8)	3 (4.7)	0 (0.0)	16 (25.0)	0 (0.0)	1 (1.6)
	Widowed	1 (2.7)	11 (29.7)	0 (0.0)	25 (67.6)	0 (0.0)	0 (0.0)
Missing = 26							

Table 11 reveals a greater tendency for male patients to return to their family of origin after a divorce or separation (51%), whereas in the case of the female patients the tendency was to live with their children (42.2%) or alone (42.2%).

There was a higher percentage of single male patients living with their family of origin (77.2% vs. 68.8%). Although there were significantly more widowed female patients than males, a larger percentage of females lived with their children (29.7% vs. 16.7%), whereas most widowed male patients lived alone (83.3% vs. 67.6%).

1.1.4. Gender and ICD-10 Diagnoses

Table 12 presents the patients classified according to the diagnoses received during the first admission to the Psychiatric Inpatient Unit, and the comparison between male and female groups. Statistical analysis, using Pearson Chi-square, showed that there were significant differences in diagnoses between the two genders ($\chi^2=38.861$; $p<0.001$). *Mood (affective) disorders* (ICD-10 Codes F30 – F39) was the most frequent diagnosis with a prevalence of 56.5% (n=307), followed by *Schizophrenia, schizotypal and delusional disorders* (ICD-10 Codes F20 – F29), which corresponded to 23.8% (n=129), and *Organic, including symptomatic, mental disorders* (ICD-10 Codes F00 – F09), with a prevalence of 5.2% (n=28).

Of all the diagnoses made in the inpatient unit, 19 (3.5%) did not fall under the ICD-10 chapter of *Mental and Behavioural Disorders*.

The comparison between genders showed a higher prevalence of mood (affective) disorders in female patients (66.3 vs. 44.6%). Male patients had a higher prevalence rate of *Schizophrenia, schizotypal and delusional disorders* (29.6 vs. 19.6%) and of *Mental and behavioural disorders due to psychoactive substance use* (ICD-10 Code F10 – F19) (4.7 vs. 0.3%) than female patients.

TABLE 12 – PSYCHIATRIC AND NON-PSYCHIATRIC DIAGNOSES ACCORDING TO ICD-10 BY GENDER.

Diagnoses	Code	N 543 (%)	Male (n=234) %	Female (n=309) %
Physical and Organic Disorders and Factors influencing Health Status	*	19 (3.6)	14 (6.0)	5 (1.8)
Organic, including symptomatic, mental disorders	F00 – F09	28 (5.2)	11 (4.7)	17 (5.6)
Mental and behavioural disorders due to psychoactive substance use	F10 – F19	12 (2.2)	11 (4.7)	1 (0.3)
Schizophrenia, schizotypal and delusional disorders	F20 – F29	129 (23.8)	69 (29.6)	60 (19.6)
Mood (affective) disorders	F30 – F39	307 (56.5)	104 (44.6)	203 (66.3)
Neurotic, stress-related and somatoform disorders	F40 – F49	16 (2.9)	8 (3.4)	8 (2.6)
Disorders of adult personality and behaviour	F60 – F69	18 (3.3)	9 (3.9)	9 (2.9)
Other Mental and behavioural Disorders	**	10 (1.9)	7 (3.0)	3 (1.0)
Missing		4 (0.7)		

* A00 – B99; C00 – D48; E00 – E90; G00 – G99; I00 – I99; J00 – J99, M00 – M99; N00 – N99; Z00 – Z99

** F50 – F59; F70 – F79; F80 – F89

1.1.5. Sociodemographic characteristics and Psychiatric Diagnoses by Ethnicity

The comparison of the mean age between Caucasians and non-Caucasians, admitted for the first time to the Psychiatric Department (Table 13) showed that non-Caucasians were significantly younger (36.1 vs. 47.4 years, t -test=6.431, $p<0.001$).

TABLE 13 – AGE AND ETHNIC GROUP AT INDEX-ADMISSION

Ethnic Group	N (%)	Mean Age (years)	Standard Deviation	Test	p
Caucasian	430 (79.2)	47.4	17.314	t-test	<0.001
Non-Caucasian	113 (21.0)	36.1	13.724		

The association between other sociodemographic characteristics and Ethnicity, (Table 14) showed that there were some significant differences between Caucasian and non-Caucasian patients.

TABLE 14 – SOCIODEMOGRAPHIC CHARACTERISTICS AND ETHNICITY

Ethnicity Admissions	Caucasian n= 430 (%)	Non-Caucasian n= 113 (%)
Gender		
Male	179 (41.6)	55 (48.7)
Female	251 (58.4)	58 (51.3)
Occupational Status		
Student	16 (4.0)	11 (9.9)
Unemployed	129 (32.3)	46 (41.4)
Employed	132 (33.0)	39 (35.1)
Retired	106 (26.5)	9 (8.1)
Sick-leave	9 (2.3)	4 (3.6)
Home-maker	8 (2.0)	2 (1.8)
Missing	30	2

Ethnicity	Caucasian	Non-Caucasian
Admissions	n= 430 (%)	n= 113 (%)
Education (years)		
Illiterate	14 (4.2)	2 (2.2)
1 to 4	64 (19.2)	8 (8.9)
5 to 9	105 (31.5)	41 (45.6)
10 to 12	77 (23.1)	22 (24.4)
>12	26 (7.8)	9 (10.0)
Superior or more	47 (14.1)	8 (8.9)
Missing	97	23
Marital Status		
Married/Cohabiting	169 (41.5)	36 (32.1)
Divorced/Separated	78 (19.2)	13 (11.6)
Single	120 (29.5)	59 (52.7)
Widowed	40 (9.8)	4 (3.6)
Missing	23	1

Concerning occupational status there were significantly more non-Caucasian patients that were students (9.9 vs. 4%), and unemployed (41.4 vs. 32.3%). On the other hand, Caucasian patients (26.5 vs. 8.1%) were more frequently retired ($\chi^2=21.708$, $p=0.001$).

As for the variable Education, the differences between the two groups were borderline significant ($\chi^2=11.167$, $p=0.048$). Caucasians were more frequently illiterate (4.2% versus. 2.2%), and had more frequently completed between 1 to 4 years of education (19.2% versus. 8.9%) than non-Caucasians.

A higher rate of non-Caucasian patients (45.6% versus. 31.5%) had between 5 to 9 years of education. This trend was maintained until the level of superior education, where the pattern inversed and there were more Caucasians with superior education (14.1 versus. 8.9%).

There were also very significant differences concerning marital status ($\chi^2=22.573$, $p<0.001$). The Caucasian patients were more frequently married/cohabiting (41.5 vs. 32.1%), divorced/separated (19.2 vs. 11.6%) or

widowed (9.8 vs. 3.6%. On the other hand, the majority of the non-Caucasian patients (52.7%) were single at the time of their first admission.

Table 15 presents the distribution of patients according to ICD-10 Diagnoses by ethnic group. Caucasian patients had a higher percentage of Organic mental disorders (F00 – F09), (6.1 vs. 1.8%) and of Mood (affective) disorders (51.3 vs. 40.7%) than non-Caucasians.

Non-Caucasians were more frequently diagnosed with Schizophrenia, Schizotypal and delusional disorders (F20 – F29), (44.2 vs. 18.5%), and psychoactive substance use (5.3 vs. 1.4%). However, it was not possible to verify if there were statistically significant differences between the two ethnic groups.

TABLE 15 - DIAGNOSES AND ETHNICITY

Diagnoses	Code	Caucasian Admissions n= (%)	Non- Caucasian Admissions n= (%)
Physical and Organic Disorders and Factors influencing Health Status	*	14 (3.1)	5 (4.5)
Organic, including symptomatic, mental disorders	F00 – F09	26 (6.1)	2 (1.8)
Mental and behavioural disorders due to psychoactive substance use	F10 – F19	6 (1.4)	6 (5.3)
Schizophrenia, schizotypal and delusional disorders	F20 – F29	79 (18.5)	50 (44.2)
Mood (affective) disorders	F30 – F39	261 (51.3)	46 (40.7)
Neurotic, stress-related and somatoform disorders	F40 – F49	15 (3.5)	1 (0.9)
Disorders of adult personality and behaviour	F60 – F69	16 (3.8)	2 (1.8)
Other Mental and behavioural	**	9 (2.1)	1 (0.9)
Missing			

* A00 – B99; C00 – D48; E00 – E90; G00 – G99; I00 – I99; J00 – J99, M00 – M99; N00 – N99; Z00 – Z99

** F50 – F59; F70 – F79; F80 – F89

1.2. Process

1.2.1. PER use

Regarding the study sample (N=543), 382 (70.3%) of the patients had one visit to the PER, the visit that originated their admission to the Inpatient Unit and 4 (0.7%) had never been attended in the PER. The remaining 157 (28.2%) patients had 2 or more PER visits prior to being admitted. Of these more frequent PER users, 99 (63.1%) were female, 132 (84.1%) were Caucasian, the mean age was 42.4 ± 15.2 years, 67 (42.7%) were married/cohabiting, followed by 42 (26.8%) patients whom were single and 34 (21.7%) were divorced/separated. Of these frequent PER users 54 (34.4%) were employed, 49 (31.2%) unemployed, and 31 (19.7%) were retired. The main diagnoses of these patients were Mood/affective disorders, which represented 63%, followed by 19.7% who suffered from Schizophrenia / schizotypal / delusional disorders.

Concerning the variable “*Previous contact with the Psychiatric Departments’ Functional Units*”, 283 patients (73.5% vs. 26.5) that had 0 or 1 PER visit prior to index-admission, had no previous contact with any unit of the psychiatric department. In the group of frequent PER users, 107 (68.2%) had at least one contact with the Psychiatric Departments’ Functional Units prior to index-admission. These differences were statistically significant ($\chi^2 = 81.695$, $p < 0.001$).

TABLE 16 – PER VISITS BEFORE AND AFTER INDEX-ADMISSION

PER visits N=543	Mean	Minimum	Maximum	Std. Deviation	Test	P
Before admission	1.5	0	20	1.3	t-test	<0.001
After Discharge	0.7	0	12	1.4		

A significant difference in the mean number of visits to the PER before admission and after discharge in the total sample was found (Table 16). Before admission the mean number of visits to the PER (1.5 ± 1.3) was significantly greater than the mean number of visits (0.7 ± 1.4) after discharge from the inpatient unit, and during follow-up (t-test=11.101, $p < 0.001$).

Although the mean Length of Stay (LOS) in the Inpatient unit of the recurrent PER users was higher compared to that of the first time PER users (23.5 ± 34.2 vs. $20.9, \pm 16.2$ days), this difference was not statistically significant (Mann-Whitney $U=28527.500$, $p=0.284$).

Comparison between the number of visits to the PER before admission and after discharge during follow-up, showed that 406 (75%) patients had less visits to the PER during the follow-up period than prior to first admission, 75 (14%) had the same number of PER visits before and after admission, and 62 (11%) had an increase in the number of PER visits post-discharge.

There was also a significant decrease in the number of PER visits by the frequent users ($\chi^2 = 8.880$, $p=0.003$).

The group of patients discharged to other medical departments in the Hospital, transferred to the Hospital of their area of residence, to private practices or to their GPs [$n=120$ (22.1%)], also presented a significant decrease in PER use after discharge (t-test = 11.048, $p < 0.001$).

As shown in Table 17, 97.1% of all the patients were admitted via the PER. The patients that had a direct or programmed admission were referred to the inpatient Unit by the community mental health teams, and were admitted without passing through the PER. Subsequently changes were introduced into this referral system, and since that, this group of patients have to go through the PER before admission to the inpatient unit.

Table 17 also shows that the percentage of first admissions coming from Queluz/Massamá area of residence is much higher than from the other areas.

TABLE 17 – ORIGIN AND AREA OF RESIDENCE OF PATIENTS ADMITTED TO THE INPATIENT UNIT

N=543	n (%)
Origin	
PER	527 (97.1)
Medical Departments	9 (1.7)
Direct	6 (1.1)
Programmed	1 (0.2)
Area of Residence	
Amadora	111 (20.4)
Brandoa	110 (20.3)
Damaia	125 (23.0)
Queluz/Massamá	175 (32.2)
Out of Catchment area	22 (4.1)

Of all the patients first admitted, 334 (61.5%) had no previous contact neither with the Community teams nor the Liaison Psychiatry team. The remaining 209 (38.5%) patients had at least one contact with the Functional Units of the Psychiatric Department, other than PER visits, prior to first admission. Of the patients with previous contact, 178 (85.2%) were Caucasian and 31 (14.8%) non-Caucasian, and this difference was statistically significant ($\chi^2 = 7.461$, $p=0.006$).

1.2.2. Voluntary and involuntary first admissions

Involuntary admissions accounted for 106 (19.5%) of all the first admissions between 2008 and 2010. There were no significant differences in the mean age between the patients who were admitted involuntarily (43.6 ± 17.2 years vs. 45.5 ± 17.2 years) compared to those that had voluntary admissions, nor between Caucasian and non-Caucasian patients.

As for other sociodemographic characteristics shown on Table 18 the involuntarily admitted group presented a significantly higher prevalence of males (54.7 vs. 40.3%, $\chi^2 = 7.256$, $p=0.007$), and of single patients than those that were admitted voluntarily (53.5 vs. 29.9%, $\chi^2 = 23.1$, $p<0.001$).

TABLE 18 – SOCIODEMOGRAPHIC CHARACTERISTICS OF PATIENTS WITH INVOLUNTARY VERSUS VOLUNTARY ADMISSIONS.

Involuntary/Voluntary Admissions	Involuntary n= 106 (%)	Voluntary n= 437 (%)
Gender		
Male	58 (54.7)	176 (40.3)
Female	48 (45.3)	261 (59.7)
Ethnicity		
Caucasian	82 (77.4)	348 (79.6)
Non-Caucasian	24 (22.6)	89 (20.4)
Occupational Status		
Student	5 (5.1)	22 (5.3)
Unemployed	47 (48.9)	128 (31.0)
Employed	23 (23.5)	148 (35.8)
Retired	19 (19.4)	96 (23.2)
Sick-leave	2 (0.4)	11 (2.2)
Home-maker	2 (2.0)	8 (1.9)
Missing	8	24
Education (years)		
Illiterate	3 (3.8)	13 (3.8)
1 to 4	12 (15.4)	60 (17.4)
5 to 9	26 (33.3)	120 (34.8)
10 to 12	21 (26.9)	78 (22.6)
>12	7 (9.0)	28 (8.1)
Superior or more	9 (11.5)	46 (13.3)
Missing	28	92
Marital Status		
Married/Cohabiting	22 (21.8)	183 (43.8)
Divorced/Separated	17 (16.8)	74 (17.7)
Single	54 (53.5)	125 (29.9)
Widowed	8 (7.9)	36 (8.6)
Missing	5 (4.7)	19 (4.3)

In relation to Diagnoses and types of admission (Table 19), although it was not possible to use parametric tests to compare both groups due to the fact of many cells having values below 5, there were however, differences between the two groups.

The diagnoses in the Schizophrenia, schizotypal and delusional disorders group (ICD 10 Codes, F20-F29), were more prevalent in the involuntarily admitted group (39.6 vs. 20%), and the diagnoses in the Mood (affective) disorders group (ICD 10 Codes, F30-F39) more prevalent amongst the voluntarily admitted group of patients (59.7 vs. 43.4%).

Although the sub-samples of involuntary versus voluntary admissions do not have a normal distribution in the variable LOS according to the K-S test, nor by the observation of the histograms and the qqplots, the Central Limit Theorem enables the use of parametric tests to compare the statistical significance of the variable LOS.

TABLE 19 – PSYCHIATRIC DIAGNOSES OF INVOLUNTARY AND VOLUNTARY ADMISSIONS

Diagnoses	Code	Involuntary Admissions n=106 (%)	Voluntary Admissions n=437 (%)
Physical and Organic Disorders and Factors influencing Health Status	*	1 (0.9)	18 (3.6)
Organic, including symptomatic, mental disorders	F00 – F09	4 (3.8)	24 (5.5)
Mental and behavioural disorders due to psychoactive substance use	F10 – F19	1 (0.9)	11 (2.5)
Schizophrenia, schizotypal and delusional disorders	F20 – F29	42 (39.6)	87 (20.0)
Mood (affective) disorders	F30 – F39	46 (43.4)	261 (59.7)
Neurotic, stress-related and somatoform disorders	F40 – F49	4 (3.8)	12 (2.7)
Disorders of adult personality and behaviour	F60 – F69	3 (2.8)	15 (3.4)
Other Mental and behavioural	**	3 (1.8)	7 (1.5)
Missing			

* A00 – B99; C00 – D48; E00 – E90; G00 – G99; I00 – I99; J00 – J99, M00 – M99; N00 – N99; Z00 – Z99

** F50 – F59; F70 – F79; F80 – F89

In accordance, and as shown in Table 20, it is possible to state that patients with involuntary admissions had a significantly higher LOS (27.9 ± 21.6 days) than those who were admitted voluntarily (20.1 ± 23.0 days), (t-test=3.177, p=0.002).

TABLE 20 – INVOLUNTARY AND VOLUNTARY ADMISSIONS AND LOS

LOS (days)	Mean	Minimum	Maximum	Std. Deviation	Test	p
Involuntary Admission (n=106)	27.9	2	125	21.6	t-test	0.002
Voluntary Admission (n=437)	20.1	1	369	23.0		

1.2.3. Physical Restraint during first admission

One hundred and six patients (19.5%) were physically restraint during their first admission. They were mainly males (n=60, 56%) and Caucasian (71.1%), and their mean age was $42,5 \pm 17.6$ years.

Contrary to the expected, the patients who were admitted involuntarily had the same rate of physically restraint than those with voluntary admissions (50 vs. 50%). The physically restraint patients presented more frequently a Mood/affective disorders diagnosis (58.5%), followed by Schizophrenia/Schizotypal and delusional disorders (29.2%).

Of the 106 patients restraint physically, 24 (22.6%) displayed no risk behaviour recorded by the Inpatient Units' nursing staff. Fifty-nine (55.7%) patients displayed violent behaviour towards others (patients and staff), 29 (27.4%) were at risk of absconding from the Psychiatric Inpatient Unit, 20 (18.9%) presented risk of self-harm, 15 (14.2%) had demonstrated risk of suicide, and 10 (9.4%) patients were physically restraint due to the risk of falling.

As shown in Table 21, there were some statistically significant differences in the pattern of risk factors/behaviours when comparing male and female patients.

TABLE 21 – GENDER AND RISK FACTORS/BEHAVIOURS.

	Suicide Risk n=123 (22.7%)	Risk of Self-harm n=73 (13.4%)	Violence to others n=147 (27.1%)	Risk of Absconding n=71 (13.1%)	Risk of Falling n=31 (5.7%)	Risk of Arson n=3 (0.6%)
Gender						
Male	37 (30.1)	27 (37.0)	81 (54.4)	42 (59.2)	12 (38.7)	0 (0.0)
Female	86 (69.9)	46 (63.0)	67 (45.6)	29 (40.8)	19 (61.3)	3 (100.0)
Missing n=27						

Female patients displayed higher risk of suicide than male patients (69.9 vs. 30.1%, $\chi^2=11.681$, $p=0.001$), whereas male patients demonstrated higher levels of aggressive behaviour towards others (54.4 vs. 45.6%, $\chi^2=10.145$, $p=0.001$), and were at higher risk of absconding from the inpatient ward than the female patients (49.2 vs. 40.8%, $\chi^2=8.307$, $p=0.004$).

Pertaining to risk factors/behaviour and LOS in the inpatient unit, in average there were slight differences when compared to patients who had no register of any form of risk behaviour. The only statistically significant difference in LOS (t-test= -3.225, $p=0.001$) was that of patients who were at risk of suicide (15.9 ± 13.4 days) when compared to patients who had not manifested risk of suicide (23.5 ± 24.9 days).

1.2.4. Comorbidity - Alcohol and Substance use

Tobacco, alcohol and substance use and abuse were also registered in the patients' clinical files. Regarding these health risk factors, 170 (31.3%) patients were smokers, 115 (21.2%), heavy consumers of alcoholic beverages, and 77 (14.2%) had some type of substance use and/or abuse.

Heavy consumers of alcohol were younger (mean 38.8 ± 12.9) than the study sample (mean 45.1 ± 17.2), 83 (72.2%) were male, 82 (71.3%) Caucasian,

51 (44.3%) were single, followed by 36 (31.3%) who were married/cohabiting. The education level of the majority (61.1%) was less than or equal to the ninth grade, and 60 (52.2%) were unemployed, followed by 38 (33%) who were employed. The most frequent diagnoses were Mood/affective disorders (53.9%), followed by Schizophrenia/schizotypal and delusional disorders (23.5%), and Mental and behavioural disorders due to psychoactive substance use (8.7%). Their mean LOS was 24.2 ± 36.8 days.

Concerning patients that were substance users and/or abusers, their mean age (29.3 ± 10.2) was significantly lower than the mean age of the study sample, 60 (77.9%) were male, 64 (83.1%) were Caucasian, and 52 (67.5%) were single, followed by 13 (16.9%) who were married/cohabiting and 12 (15.6%) were divorced/separated. The education level of the majority (57.7%) was less than or equal to the ninth grade. However, in comparison to the patients whom were heavy consumers of alcohol, these had a higher percentage of university graduates (9.6%) than the patients who were substance users/abusers (3.9%). With reference to the occupational status of the latter, 55 (71.4%) were unemployed, followed by 10 (13.0%) who were employed. The most frequent diagnoses were Mood/affective disorders, which accounted for 49.4%, followed by Schizophrenia/schizotypal and delusional disorders (29.9%), and Disorders of adult personality and behaviour (7.8%). The mean LOS in this group was 26.2 ± 43.2 days).

A subsample of 38 patients combined alcohol with other psychoactive substance use/abuse, representing 7.0% of the total sample. They had a mean LOS of 30.8 ± 59.3 days, and 30 (78.9%) were discharged to the Departments' community teams. They had a greater mean number of psychiatric appointments a year after discharge (5.9 vs. 4.6, $p=0.07$) in comparison to patients who had no documented alcohol or substance use/abuse.

1.2.5. Length of stay (LOS) in the Psychiatric Inpatient Unit

The mean LOS in the Psychiatric Department's inpatient unit was 21.6 ± 22.9 days, ranging from 1 to 369, and the median was 17 days.

Due to the large range in the LOS, an analysis of the outliers was performed. As there is apparently not a consensus on this matter, the outliers were considered, by the author's convention, to be all those above the 95 percentile.

These patients (n=26, 4.8%) had a LOS equal or superior to 50 days, their mean age was 53.6 ± 15.6 years, ranging from 22 to 84 years, older in comparison with the whole the sample (45.1 years). Although it was not possible to assess if the reasons for the extended LOS were due to clinical or social factors, these patients had statistically significant more contacts ($\chi^2=4.566$, $p=0.033$) with the Departments' social workers (42.3 vs. 23.8%), and a higher prevalence of Schizophrenia, schizotypal and delusional disorders than that found in the total sample (38.5 vs. 23.8%).

1.2.6. Period between discharge and First Psychiatric Appointment

From the original sample of 543 patients, 423 (78.0%) patients were referred at discharge either to the community teams in their area of residence or to the Liaison Psychiatry unit. The mean period between discharge and the first psychiatric appointment attended by these patients was 29.7 ± 61.8 days, with a variation between 1 and 593. The period between discharge and first appointment attended was greater than 15 days in 175 patients (41.4%).

The remaining 120 patients were referred to other facilities or health/mental health professionals.

1.2.7. Readmissions

One hundred patients (18.4%) were readmitted at least once during the follow-up period of the study. Of these readmissions, 55% were female patients, 77% of Caucasian ethnicity, the mean age was 39.4 ± 17.2 years, and the majority between 16 and 44 years (67%). They represented 25% of the involuntary first-admissions, and 7% of the readmissions were due to the

administration of electroconvulsive therapy. At time of discharge from the index-admission, 79% had been referred to the Psychiatric Department's Community teams, 5% had been discharged against medical judgment or had absconded from the inpatient unit and 5% had been transferred to other hospitals because they did not reside in the Department's catchment area. The main diagnoses were Mood/affective disorders (62%) followed by Schizophrenia/schizotypal and delusional disorders, and alcohol use/abuse (25% each), and 21% were active psychoactive substance users/abusers.

1.2.8. Readmissions ≤ 15 days after discharge from the Inpatient Unit

The total number of patients readmitted during the fortnight following discharge was 16 (2.9% of the total sample), of which 9 (56.3%) were female, 12 (75%) Caucasian, and their mean age was 37.5 ± 20.4 years. In this group of patients, 10 (62.5%) were single, followed by 4 (25%) who were married/cohabiting. Seven (43.8%) had between 5 and 9 years of education followed by 6 (42.9%) who had reached between 10 and 12 years of education, but none had a college/university degree. The majority, 56.3% (n=9) were unemployed, 12.5% (n=2) were employed, 12.5% (n=2) were students and the remaining 3 patients (18.8%) were either retired or home-makers. The first admission for 18.8% (n=3) had been an involuntary admission. Eleven (68.8%) of these patients had been diagnosed with a Mood/affective disorder, followed by 2 (12.5%) with a diagnosis of Schizophrenia, schizotypal and delusional disorder. One (6.3%) was diagnosed with a personality disorder, and the remaining two patients did not have a psychiatric diagnosis as their principal diagnosis. Concerning substance use/abuse, 25% had a history of alcohol abuse and 25% were drug abusers.

With reference to risk behaviour recorded during first-admission, 37.5% had risk of suicide, 18.8% risk of absconding from the inpatient ward, 31.5% had risk of self-harm, 37.5% had displayed violent behaviour towards others, and one patient had risk of arson.

In addition to the four patients (25%) that were readmitted in this period due to ECT treatment, causes underlying the other 12 readmissions were:

- 3 - use/abuse of psychoactive substances and/or alcohol;
- 2 - suicide attempts;
- 2 - aggravated family conflicts;
- 2 - discharge at first admission, against medical advice (patient and or family member signed a term of responsibility);
- 1 - adverse side effects of the psychotropic medication;
- 1 - organic mental illness, and
- 1 - administrative confusion about the patient's address and the hospital's catchment area (patient was transferred and back-transferred between the HFF and another hospital).

1.2.9. Discontinuation of treatment during follow-up

Of the total sample of 543 patients, 82 (15.1%) discontinued treatment during the follow-up period, but 50 (61%) were given discharge by their psychiatrist. Of these, 22 were effectively discharged due to an improvement in their clinical condition, 22 due to the fact they resided or moved out of the Hospital's catchment area, and 6 were institutionalized, either in old-age homes or in mental institutions.

Concerning the remaining 32 patients, 9 deceased, and 23 patients (28%) were drop-outs, which corresponds to 4.2% of the total study sample.

In fact, according to the information given by the community mental health teams, 5 of the patients that had dropped-out during this study's follow up period, later returned to the teams.

TABLE 22 – DISCONTINUATION DURING FOLLOW-UP

Discontinuation during follow-up n=82 (15.1%)				
Discharged Clinical improvement	Discharged Change in residence	Institutionalized	Deceased	Drop-out
22 (27.0%)	22 (27.0%)	6 (7.2%)	9 (10.8%)	23 (28%)

1.2.10. Further Care

In addition to psychiatric appointments, the patients' mental health care process may involve the participation of other professionals, or functional units/facilities of the Psychiatric Department. Concerning the intervention of other mental health professionals, 47.3% of the patients had at least one contact with the teams' nurses, 24.7% an interview with a social worker, and 8.7% were assessed or had psychotherapeutic interventions by the community team's psychologists. The number of contacts during follow-up ranged from 1 to 433. The large number of contacts can be explained by the need to ensure compliance, through assistance with oral medication. In some cases patients were given their medication on a daily basis at the community mental health unit. On the other hand, 15.7% of the study sample had prescribed anti-psychotic depot medication, which also implied regular visits to the team nurses. During the follow-up period, 9.9% of all the patients had conjoint activities, which may be defined by activities/appointments/sessions that were performed with the simultaneous presence of at least two mental health professionals, and do not include the home visits. Furthermore, 3.5% of the sample received home visits during the follow-up.

The care process may also include referrals to the Departments' Day-centres, which received 3.9% of the study sample, the Day Hospital, with 4.4% referrals, in addition to 5.7% of the sample that was referred to the Day Hospital to participate in a Psychoeducational activity for patients with the diagnosis of Bipolar Disorder.

1.3. Outcome

Patients' satisfaction with the Psychiatric Department and the mental health care received was assessed with resource to the VSSS.

Of the initial 103 questionnaires sent to a randomized sample, 34 (33.3%) were returned and the mean scores obtained in each of the different domains that constitute the instrument are presented in table 23.

Fifty eight female patients and 45 male patients constituted the randomized sample, and 19 female and 15 male patients returned the questionnaires. The mean age of the respondents was 43 years, close to that of the total sample.

TABLE 23 – MEAN SCORES OF PATIENTS' SATISFACTION MEASURED BY VSSS.

	Access	Information	Professionals' skills and behaviour	Efficacy	Relatives' involvement	Types of Interventions	Overall Satisfaction
Mean Score	3.4	3.5	3.7	3.6	3.2	1.3	3.7

The overall satisfaction was 3.7 points out of a maximum of 5.0. All domains except one showed a mean score above 3. The domain, in which the patients showed a greater degree of satisfaction was in the Professionals' skills and behaviour (3.7 points), followed by the Efficacy of care received (3.6 points) and the Information received about the diagnoses and medication (3.5 points). The Domain that revealed least satisfactory was the Types of Interventions made available by the community mental health teams (1.3 points).

Table 24 shows the Specific interventions included in the VSSS, and those that the patients in fact received (column YES). Although the VSSS requests information about the care received during the past year, the patients

were requested to take into account the entire period between post-discharge and the present.

The majority of respondents (88.2%) had received prescribed medication, and the mean score concerning satisfaction with the prescribed medication was 4.2 out of a total of 5 points on the scale.

TABLE 24 – SPECIFIC DEPARTMENT INTERVENTIONS (ITEMS 41-54 OF THE VSSS) RECEIVED OR NOT RECEIVED BY PATIENTS.

Specific Interventions	Yes N (%) (mean score)	No + would not have liked to N (%)	No + do not know N (%)	No + would have liked to N (%)
Medication Prescription	30 (88.2%) (4.2)	3 (8.8%)	1 (2.9%)	-
Individual Rehabilitation	24 (70.6%) (3.9)	5 (14.7%)	1 (2.9%)	4 (11.8%)
Individual sessions	17 (50%) (3.6)	6 (17.6%)	4 (11.8%)	7 (20.6%)
Compulsive Admission	7 (20.6%) (2.4)	22 (64.7%)	3 (8.8%)	2 (5.9%)
Family Sessions	4 (11.8%) (2.5)	13 (38.2%)	9 (26.5%)	8 (23.5%)
Sheltered accommodation	2 (5.9%) (3.5)	28 (82.3%)	3 (8.8%)	1 (2.9%)
Recreation within Department	6 (17.6%) (2.7)	16 (47.1%)	8 (23.5%)	4 (11.8%)
Group Sessions	7 (20.6%) (2.8)	15 (44.1%)	8 (23.5%)	4 (11.8%)
Sheltered work	-	19 (55.9%)	4 (11.8%)	11 (32.3%)
Voluntary admission	7 (20.6%) (3.0)	23 (67.6%)	3 (8.8%)	1 (2.9%)
Practical help at home	1 (2.9%) (5.0)	27 (79.4%)	2 (5.9%)	4 (11.8%)
Welfare Benefits	8 (23.5%) (3.0)	11 (32.3%)	1 (2.9%)	14 (41.2%)
Help to find open employment	-	20 (58.8%)	3 (8.8%)	11 (32.3%)
Recreation outside Department	2 (5.9%) (3.0)	14 (41.2%)	9 (26.4%)	9 (26.4%)

Regarding individual rehabilitation, 70.6% had received some sort of individual rehabilitation, with a mean satisfaction score of 3.9, and 50% stated that they had received individual sessions, with a mean score of 3.6. Concerning the individual sessions, 50% stated that they had not received individual sessions and 20.6% would have like to. The question in the VSSS concerning individual sessions, is not clear, because the question (Have you had individual sessions with your therapist?) does not differentiate between psychiatrist and psychologist, which could have lead to some patients considering the individual sessions with their psychiatrist, and others considering individual psychotherapy with a psychologist when answering the question.

Of the total of 34 respondents, 14 (41.2%) patients had been readmitted to the inpatient ward, 7 of which had involuntary admissions and 7 were voluntary. Patients with involuntary admissions rated the experience as having been unsatisfactory (2.4 vs. 3.0).

Although patients had a mean score on the domain Relatives' Involvement of 3.2 (table 23), Table 24 shows that 23.5% of the patients had not received family sessions but would have liked to.

None of the patients were integrated in sheltered work, but almost a third (32.3%), which corresponds to 11 patients, would have liked to be helped in finding a job in a sheltered work place. The majority of the patients (79.4%) stated that they would not have liked to receive practical help at home.

Concerning welfare benefits, 23.5% had received help from the CMHT (articulation with the social worker, psychiatric clinical report, and psychological assessment), and the mean satisfaction score was 3.0 points. A further 41.2% had not received help with obtaining a welfare benefit, but wished that they could have been aided by their CMHT. None of the patients had received help in finding open employment, but almost a third (32.3%) of the patients expressed their wish to have received aid on this matter.

As for recreational activities in the community, 26.4% expressed the need for help from the CMHT in finding this sort of activities in their area of residence.

1.3.1. Content analysis of open-ended questions

‘The thing I liked most is...’

The characteristics more frequently referred were associated with the competence/”profound knowledge” and support of the mental health professionals, in addition to the empathic nature of the therapeutic relationship. For example: “Availability, affection and support of the professionals”, “Good service that takes into account our needs”, “Medical care in the inpatient ward and in the community”, “Frankness and dedication of the professionals – psychiatrists and nurses”, “Stability and honesty of all the professionals”, “The occupational therapy in the inpatient ward”, “I liked all the professionals, but especially the occupational therapist”, “The way in which the department captivates the patients, and the support received by the nursing staff”.

‘The thing I disliked most is...’

On the other hand, the characteristics mostly referred as having a negative impact on the patients were associated to their stay as inpatients, and to the appointments at the CMHC centres. Concerning the inpatient ward - “A large quantity of people with the most diverse diagnoses”, “Unavailability of the auxiliary staff in the ward”, “Lack of psychological therapy”. In the community, the patients referred “Long waiting time before my appointments, and the duration of my appointments are usually about 15 minutes”, “Lack of comprehension/understanding concerning the patients’ behaviours”, “Far from home”, “The assistance in the community”, “The social worker and the shock when I was told my diagnosis”.

PART 5



DISCUSSION AND CONCLUSION

1. Discussion

The present study reveals some very interesting data on the Structure, Process and Outcome of the Psychiatric Department of the Hospital Prof. Dr. Fernando Fonseca. These three components of the mental health care process will be discussed while broaching the objectives and hypothesis of the study and in further depth later on.

1.1. Objectives

Presently an analysis of four study objectives will be examined.

*The **first objective** was to characterize the patients with severe mental illness, who were admitted to the inpatient ward for the first time during the study period.*

Research performed on the sociodemographic and diagnostic characterization of patients with severe mental illnesses is plentiful, however most of the studies analyze specific diagnostic groups. There are to date and to our knowledge, few studies that share the same characteristics of this study, therefore comparison and model data are scarce.

*The **second objective** was to analyze whether the Department's quality indicators were achieved.*

- ***The first quality indicator is the attendance of a Psychiatric appointment during the 15 days after discharge.***

Although the majority of the patients (58.6%) attended their first post-discharge psychiatric appointment within the quality indicators recommended time-frame, the mean period between discharge and attendance of first appointment was 29.7 days ($s=61.840$), almost double the desired period. Therefore, this quality indicator is only partially achieved, and a closer look should be taken into the underlying reasons. There may be several explanations for this divergence. On one hand, when scheduling the first follow-up appointment, the psychiatrists may be overburdened and unable to schedule the appointment during the 15-day period. On the other hand, and as expected, some patients may have been discharged to other Departments, or by request, to private psychiatrists or still may have requested discharge against medical advice, and turned back to the community mental health teams much later to pursue and ensure their treatment. Other patients may have attempted to drop-out, and not attend their first appointment. When patients do not attend their appointments, the team adopts an outreach approach and contacts the patient, or when this is not possible, home visits are scheduled with the objective of reengaging the patients. According to our experience, an effortless way to meet this quality indicator would be to guarantee a scheduled appointment with one of the CMHT's nurses in the 15-day time frame. This would allow several things; To begin with, it would be an opportunity for the patient to reengage with the community mental health nurse that she/he was introduced to during hospitalization in the inpatient unit, enhancing the patient's sense of continuity of care. Consequently, this would also allow confirmation and the promotion of compliance. The consultation with the psychiatrist could then be scheduled with more time.

- ***The second quality indicator is related to re-admissions during this marker period of 15 days after discharge.***

According to the data in this study, the total number of patients readmitted in the fortnight after discharge, was 16, which is less than three percent of the total. Of these, 4 readmissions were due to initiation of ECT treatment, and one was due to transferences and back-transferences between hospitals, due to a confusion caused by the patient's addresses and hospitals' catchment areas. In reality, the percentage of patients that were readmitted in the quality indicators time frame was circa 2.0%. Various studies state that the standard performance goal should be between 10 and 15% of readmissions within 30 days after discharge (IPRO, 2010; Jones, 2007; Hyland et al., 2008). Most research on the subject of readmissions usually focus on patient and/or service variables related to specific psychiatric departments or geographical areas and usually does not perform analyses of first-time admissions/readmissions. Although the total number of readmissions in the Psychiatric Department is beyond the scope of this study, the number of effective readmissions of first time patients is well below the international standard, which indicates that this quality indicator has been attained.

*The **third objective** of this retrospective cohort study was to examine the impact of different variables on the length of stay (LOS).*

In the current study there were variables that influenced the patients' LOS.

The mean LOS in the Psychiatric Department during the period of the study did not differ between Caucasian and non-Caucasian patients.

The association between frequency of PER use and LOS showed that recurrent PER users did in fact have a longer LOS (mean=23.5 days \pm 34.2 days) than first time PER users (mean=20.9 days \pm 16.2), and higher than the mean LOS of the study sample, but the difference was not statistically significant.

With reference to involuntary admissions and LOS, patients who were admitted involuntarily to the Department had significantly longer LOS (27.9 days \pm 21.6 days) than those who had been voluntarily admitted (20.1 days \pm 23.0 days). These findings are in accordance with other studies, that found that the LOS of patients with involuntary admissions were at least as long as, or longer, than for patients admitted voluntarily (Klinkenberg & Calsyn, 1996; Cougnard et al., 2004).

Risk of suicide was found to be the only risk factor with statistical significance when considering mean LOS, as it was shorter for patients who had risk of suicide (15.9 \pm 13.4 days) than the mean LOS of the study sample. Although some studies suggest that the critical period for increased suicide risk and effective suicide is one week after discharge, they also conclude that these patients should have a mean length of psychiatric hospitalization of at least 14 days to allow clinical stabilization (Quin & Nordentoft, 2005; Desai et al., 2005). Therefore, in the current study, albeit the mean LOS was shorter for suicidal patients, it is still above international standards. Nonetheless, other studies concluded that, in many cases the risk of suicide continues after discharge, therefore, continued care in the form of a psychiatric appointment in the period of one to two weeks after discharge are crucial, and may prevent further suicide attempts (Verdoux et al., 2001; Cotayo et al., 2005).

Patients with alcohol and/or drug comorbidity also had significantly longer LOS than those who had no form of substance use. These results were expected, as comorbidity increases complexity of care and confirm research in this area (Fisher et al., 2001; Xafenias et al., 2008).

When considering the LOS of the outliers in the study, this is, the patients who had a LOS of fifty or more days, the results demonstrate that these patients (4.8%) were significantly older than the mean age of the sample (53.6 \pm 15.6 years vs. 45.1 \pm 17.2 years). Although it was not possible to determine the cause of the increased LOS, the data suggest that there may be both social needs and severity of diagnosis variables implicated. In fact, these patients had more contacts with the social workers in the Psychiatric Department (42.3% vs. 23.8%), and were more frequently diagnosed with Schizophrenia, Schizotypal and Delusional Disorders than the rest of the sample (38.5% vs. 23.8%).

The **fourth objective** was to identify the pitfalls in the care process in order to suggest improvements in the Psychiatric Department.

One of the pitfalls encountered was related to the patients' addresses and telephone contacts, which were not up-to-date in a large number of cases. This may be considered a pitfall in the care process, because it enables or facilitates drop-outs. When a patient misses a scheduled outpatient appointment, the CMHT is unable to contact the patient hence continuity of care may be threatened.

Care must be taken when scheduling the first appointment after discharge. On one hand a psychiatric appointment scheduled within 15 days after discharge is one of the departments' quality indicators, on the other hand, this may also be fundamental in reducing the number of drop-outs. Even if the Departments has a relatively small number of first-admission patients who drop-out (4.2%), these may, in the future, pose significant increases in the number of PER visits, compulsory admissions, and readmissions as well as an increased burden on the CMHT, as a consequence of the severity of their diagnoses.

Another of the pitfalls in the care process, as seen by the VSSS, is the lack of family involvement in the care process. Although the professional/patient therapeutic relation is fundamental, and is based on trust and confidentiality, the participation of the patients' families can play an essential role in understanding the patients' difficulties and needs. Therefore, both patients and families may benefit with a more active inclusion of the latter in the care process.

When considering the characteristics of the Structure of the Psychiatric Department, and the highly qualified professionals and services that it has to offer, it appears that these are being underutilized. For example, although the Department has both psychiatric and rehabilitation objectives, a very small percentage of these first-admission patients are referred to the day-centres, to the Day Hospital, or even to the CMHTs' psychologists.

1.2. Hypothesis

H0 – *There are no differences in satisfaction with health care between patients that use the available services and those who do not use the available services.*

H1 – *There is a difference in satisfaction with health care, between patients that use the available services and those who do not use the available services.*

Due to the small size of the random sample of respondents of the VSSS, and the number of available interventions, it was not possible to perform inferential statistical analyses of the data to ascertain the presence or absence of significant differences in satisfaction between patients that used the available services and those who had not used these services. However, resorting to descriptive statistical analysis, the differences encountered between the two groups were so modest that they in reality represent no differences in satisfaction. Therefore, for this sample, and the current study, the Null Hypothesis is preserved and the alternative Hypothesis (H1) may not be assumed as true.

H2 – *There is a difference in the care process (number of interventions in the community mental health team) between patients with dual diagnoses and those who do not have dual diagnoses.*

This Hypothesis is confirmed. In fact, patients with comorbid alcohol and substance use/abuse had a greater mean number of psychiatric consultations per annum than those who did not have a dual diagnosis.

H3 – *There is a difference in the care received before admission between Caucasian and non-Caucasian patients.*

This Hypothesis is confirmed. Considering PER use, the frequent users were more frequently Caucasian (84.1%), and only 14.8% of the non-Caucasian patients had previous contact with either the CMHT or the Liaison Psychiatry team. The difference between previous contact and ethnicity was statistically significant ($\chi^2 = 7.461$, $p=0.006$).

H4 – *There is a difference in psychopathology in patients of Caucasian and non-Caucasian origin, measured by longer length of stay during first admission.*

This Hypothesis is not confirmed by hypothesis testing. Although non-Caucasian patients were more frequently diagnosed with more severe illnesses (Schizophrenia, Schizotypal and Delusional Disorders) than Caucasian patients (44.2% vs. 18.5%), the mean LOS did not differ between the two groups.

H5 – There is a difference in the length of stay between patients that have compulsory admissions and those who do not have compulsory admissions.

This Hypothesis is confirmed. Patients with compulsory admissions had statistically significant (t-test=3.177, p=0.002) longer LOS (27.9 ± 21.6 days) than patients who were admitted voluntarily (20.1 ± 23.0 days).

H6 – There is a difference in length of stay between patients that have risk behaviour and those who do not have risk behaviour.

This Hypothesis is only partially confirmed by hypothesis testing. The only risk behaviour group that shows statistically significant differences in LOS in comparison to the total sample is that of patients with suicide risk. However, the mean LOS is significantly shorter for these patients than the mean LOS of the study sample.

H7 – There are differences in satisfaction between patients with different diagnoses.

In this Hypothesis, the same situation arose as in the first two Hypotheses. However, resorting once more to descriptive statistical analysis, the data shows no statistical differences. (Patients diagnosed with Affective Disorders have an Overall Satisfaction of 3.8 versus the 3.6 scored by patients with Schizophrenia, Schizotypal and Delusional Disorders. The median was exactly the same (3.7) for both diagnostic groups). Therefore, this Hypothesis may not be accepted.

1.3. Structure

Concerning the WHO-ICMHC, and the characterization of the Psychiatric Department's Functional Units, the classification reveals a mature structure with well defined objectives in each of the Functional Units, and although there are

no perfect Psychiatric Departments, there are also no Departments that cater to all of the patients' needs. To begin with, each of the patients discharged are assigned a psychiatrist in their CMHT, which from that point on is the patients' main case-manager. The CMHTs deliver both psychiatric care and rehabilitation interventions, and by no means do the professionals take over the patients' daily tasks, they do however encourage the patients' autonomy. The Inpatient Unit's main objective is to stabilize acute patients, and take care of all their medical needs, with support from the other specialized medical departments in the Hospital. However, there is also a rehabilitative objective and an occupational therapist provides for those needs. The Day Hospital, due to its characteristics is greatly focused on the rehabilitation of the patients, and has a strong psychotherapeutic perspective, on both the group and family levels. The Liaison Psychiatry Unit has a strong psychiatric/psychotherapeutic care objective, as well as a training and formative one, which has greatly contributed to a more empathic and humane nature of the medical care in the General Hospital.

Notwithstanding the value of each functional unit's objectives, Donabedian's classification, upon which this study is based, comes to mind: "Inferences about quality are not possible unless there is a predetermined association among the three approaches, so that structure influences process and process influences outcome" (Donabedian, 2003). It is our belief that this predetermined association ought to be based on a very solid articulation between the functional units. Furthermore each functional unit has to be very cohesive, and the setting for efficient and effective teamwork. Continuity of care is only possible when this articulation and cohesion are in place, contrarily, the process of care and the outcome may be seriously affected.

1.4. Process

The number of first-ever admissions in the Psychiatric Department was between 33.3 and 40.3% of all admissions during the years studied. This number was significantly greater than a similar study by Guzzetta et al. (2010) with 21.4% first-ever admissions, of which 50% of the patients had received

some kind of treatment in the period prior to admission. In the current study 38.5% of the study sample had at least one contact with either the community or the Liaison psychiatry units prior to first admission.

In the current research, 97.1% of the sample had been admitted through the PER. For 70.3%, this had been their first visit to the PER, and 28.2% were recurrent PER users. Research displays the same pattern but had a higher rate of recurrent users (36.3%) (Bruffaerts, Sabbe & Demyttenaere, 2006). Unlike these authors, the current study demonstrated that the recurrent PER users were more frequently employed or retired, and only 31.2% were unemployed. Both studies coincided in showing, a larger percentage of female patients and a majority of married or cohabiting patients.

It is not possible to state with all certainty that the PER was the first contact with a mental health professional for the incident users, although 73.5% of the incident users had no previous contact with the Psychiatric Department prior to the PER visit and to admission. This reality is significantly different to the one in the aforementioned study (Bruffaerts et al., 2006) in which only 49.6% of the incident PER users had no prior contact with mental health services. On the other hand, in the current study, only 31.8% of the recurrent users had no previous contact with the Psychiatric Department. These results display a pattern which shows that the PER may be the first doorway into mental health care for many patients with severe mental illness, in line with research by Amaddeo et al. (2001) who conclude that “new patients often do not know how to gain access to treatment and care”.

Concerning Involuntary admission to the inpatient unit, 19.5% of all the first admissions were involuntary, and these patients were more frequently male (54.7%), and single (53.5%) in comparison to voluntarily admitted patients. Unlike the study by Webber & Huxley (2004), in the current study ethnicity was not a risk factor for compulsory admission. Kallert et al. (2008) in a systematic review show that there are no significant differences between compulsory/non-compulsory admissions concerning general psychopathology, whereas in the present study, there are differences between the two groups. Almost 40% of the involuntary patients had a diagnosis of Schizophrenia, Schizotypal and Delusional Disorders versus 20% of the voluntary group, and the latter were

more frequently diagnosed with affective disorders (59.7% vs. 43.4%). Webber & Huxley (2004), who conclude that bipolar affective disorder is an increased risk factor for compulsory admission, provide contradictory evidence. Nevertheless, Kallert et al. (2008) state that involuntarily admitted patients have either a comparable or a lower level of social functioning both at admission and at discharge. Although this characteristic was not assessed in the present research, there is general accord concerning the lower level of social functioning in patients who suffer from Schizophrenia (Cannon et al., 1997; Blanchard et al., 1998; Jones et al., 1993).

Another area where there is consensus, concerns the longer LOS in involuntarily admitted patients (Kallert et al., 2008), as was demonstrated in the present study, with a significant difference of almost 8 days longer LOS for these patients. Of the 100 patients (18.4% of the total sample), that were readmitted at least once during follow-up, 25 % had been admitted involuntarily in their index admission.

In reference to treatment discontinuity/drop-outs, Berghofer et al. (2002) in a systematic review concluded that between 22 and 63% of the patients with new episode or first-ever treatment dropped out after only one service contact. In the present study, only 23 patients (4.2%) effectively dropped out of treatment and five of these patients returned to the CMHT after follow-up. These results are very significant, and very different from studies performed in other countries. Could these results reflect efficient continuity of care, even though 41.4% of the study sample had their first appointment after discharge later than the preconized period of 15 days? We believe so.

1.5. Outcome

The outcome, and also this research's **fifth objective**, the patients' satisfaction with the mental health care received was assessed with resource of the VSSS. The Overall Satisfaction was positive, 3.7 points in a maximum of 5.0 points, but the results reveal that some of the domains are not up to standard.

Although the CMHTs operate in the community and mostly from primary health centres, patients were not satisfied with the accessibility. Even though the Department's catchment area is well furnished in terms of transportation, the catchment area of the Queluz / Massamá CMHT has a very substantial geographical area, which means that frequently patients have to use more than one means of transportation, and the fees can be very costly. Another domain that showed lower than standard satisfaction was Relatives' involvement in the care process, which is one of the pitfalls in the Department, and can be improved. Several of the professionals in the Department have had formal training in either or both Systemic Family Therapy and Behavioural Family Therapy, and even those without formal training are aware of the need for family involvement. Families may often be valuable allies, and working with them may improve the frequent high levels of expressed emotion in these families.

The domain that had the lowest score (1.3) was Types of Intervention. This domain may be improved with the efficient utilization of existing resources in the Department, and with assistance of the NGO Recomeço, which has projects for the near future that will meet some of the patients' needs.

2. Limitations of the Study

No matter how well planned a research design is, and how careful the researchers are, in all studies, and this one is no exception, there are always limitations. The first, and probably the most significant limitation in the current study was the low response rate of the subjects in the random sample who were selected to complete the VSSS. Various attempts were made to randomly select, contact and engage more subjects, but our efforts were unfortunately not very successful. This difficulty also coincides with low response rates found in other studies using satisfaction questionnaires (Killaspy et al., 2000; Ruggeri, 1994). Hypothetically, we believe that this low rate, or non-response bias, could perhaps have been slightly minimized, had the author managed to contact more

patients by telephone (landline or mobile phones) and had an opportunity to explain the study.

Another limitation, which is also frequent in retrospective studies, concerns missing data in the patients' clinical records. Despite the large size of the study sample, the data that had not been recorded in the patients' files could have further enriched this research. This will be less of a problem for future research, as the Hospital is setting up a new computerized information system and the professionals that add information to the clinical files may not be able to close the files unless all of the information has been inserted.

Finally, a limitation of the study derives from the fact that data from the Psychiatric Department of the Hospital Professor Doutor Fernando Fonseca, which has its specificities (highest rate of immigrant population in the country), and serves a population of 300.000; may not be generalized to other regions or Psychiatric Departments.

3. Conclusion

Throughout the years, as a professional working in this Psychiatric Department, I was always aware of the fact that the articulation between the several functional units was an important part of the care that we offered our patients, and my subjective perception was that we were "doing a good job". This was a perception based on my own feelings, motivation, and devotion to my Department and to the patients. Notwithstanding, this Masters Course gave me the knowledge and the tools to scientifically prove my subjectivity.

There are no ideal Health, or Mental Health Departments. In fact this study showed that the Department does indeed have some pitfalls, and I have addressed certain procedures that can and should be improved in the near future in order to enhance the quality and diversity of care that we can offer our patients and their families.

On the other hand, in comparison to the international literature, the Department boasts very low dropout rates, very low readmission rates,

especially in the fortnight after discharge, and significantly lower PER visits after discharge from the inpatient unit and after referral to the CMHTs. This leads me to conclude that continuity and comprehensiveness of care is endorsed and maintained throughout the care process. We may also conclude that the care delivered by the Department overall is effective, and is adapted and based on the patients' specific needs and problems, which can be confirmed by the outcome of positive global satisfaction with care received.

I believe with this research that I was able to demonstrate the importance of the associations between the Structure, the care Process and the Outcome. To conclude there are two points that I would like to highlight. First, although the patients demonstrated satisfaction with the mental health care received, one cannot, and should not forget about the professionals' and families' satisfaction, which are fundamental for maintaining and improving the patients' quality of life, and should never be overlooked. Secondly, I would like to highlight, and this one may be "food for thought" for the future of this Psychiatric Department, the need to empower our patients, enabling them to become an integral and acting party in the whole "Recovery" process.

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ANNEXES

➤ Annex 1 - AIESMP

***Avaliação Inicial de Enfermagem
em Saúde Mental e Psiquiátrica***
**(Initial Nurse Assessment in
Mental Health and Psychiatry)**



Avaliação Inicial de Enfermagem em Saúde Mental e Psiquiátrica

Dados Biográficos

Como prefere ser chamado: _____ Língua Materna: _____

Habilitações: _____ Profissão: _____

Religião: _____

Estado Civil: _____ Com quem vive: _____

Pessoas a contactar (nome e parentesco):

1. _____ Nº tel.: _____

2. _____ Nº tel.: _____

Situação de Saúde

Data de Admissão: ____/____/____ Hora de entrada: ____/____

Enviado por: ☐ Urgência ☐ Consulta Comunitária ☐ Outros _____

Motivo de internamento: _____

Veio acompanhado? ☐ Não ☐ Sim Por quem? _____

Outros internamentos: ☐ Não ☐ Sim Especifique: _____

Antecedentes: Pessoais _____

Familiares _____

Medicação habitual: _____

Adesão ao internamento ☐ Sim ☐ Não. Especifique _____

Consciência da doença ☐ Não ☐ Sim. Especifique _____

Avaliação do Risco (assinalar o que este em risco): ☐ Suicídio ☐ Fuga

☐ Heteroagressividade ☐ Autoagressividade ☐ Queda ☐ Fogo Posto

Avaliação Psíquica

Consciência ☐ Acordado ☐ Obnubilado ☐ Sonolento

Orientação ☐ Orientado ☐ Desorientado
☐ Tempo ☐ Espaço ☐ Próprio ☐ Autopsíquica ☐ Alopsíquica

Apresentação

Expressão facial ☐ Aberta ☐ Fechada ☐ Inexpressiva
☐ Móvel ☐ Parada ☐ Especifique _____

Olhar ☐ Directo ☐ Fugidio ☐ Fixo ☐ Saltitante
☐ Sombrio ☐ Outro _____

Postura ☐ Desordenada ☐ Excêntrica ☐ Com maneirismos
☐ Adequada ☐ Outro _____

Comportamento ☐ Cooperante ☐ Viscoso ☐ Indiferente ☐ Renitente
☐ Hostil ☐ Negativista ☐ Outro _____

Atenção Fixável ☐ Não captável ☐ Captável não fixável ☐ Outra _____

Memória **Imediata** ☐ Normal ☐ Alterada
Recente ☐ Normal ☐ Alterada **Remota** ☐ Normal ☐ Alterada

Pensamento

☐ Coerente ☐ Incoerente ☐ Acelerado ☐ Lentificado ☐ Ideofugitivo
☐ Obsessivo ☐ Ideias sobrevalorizadas
☐ **Delirante:**
☐ Perseguição ☐ Ciúme ☐ Grandeza ☐ Místico ☐ Ruína
☐ Outro _____

Linguagem

Débito ☐ Normal ☐ Acelerada ☐ Verborreica ☐ Monossilábica ☐ Lentificada
Interlocutor ☐ Ecolália ☐ Solilóquios ☐ Mutismo ☐ Outra _____

Percepção ☐ Sem alterações

☐ **Ilusões** Especifique _____ ☐ **Alucinações**
☐ Visuais ☐ Tácteis ☐ Gustativas ☐ Olfactivas ☐ Cinestésicas ☐ Cenestésicas ☐ Auditivas

Emoções/Afectos

☐ Sem alterações ☐ Embotamento ☐ Labilidade ☐ Frieza
☐ Ambivalência ☐ Outras _____

Humor

☐ Eutímico ☐ Depressivo ☐ Hipotímico ☐ Hipertímico ☐ Disfórico
☐ Eufórico ☐ Ansioso ☐ Outro _____

Psicomotricidade

☐ Calmo ☐ Agitado ☐ Agressivo ☐ Apático ☐ Lentificado
☐ Acatísia ☐ Negativista ☐ Rigidez muscular ☐ Tremores ☐ Maneirismos ☐ Tiques/
Estereotipias ☐ Outro _____

Avaliação Somática**Estado de nutrição**

☐ Normal ☐ Emagrecido ☐ Obeso ☐ Anorético ☐ Desidratado ☐ Outro _____

Alimentação

Restrições ☐ Não ☐ Sim. Especifique _____

Próteses dentárias ☐ Não ☐ Sim _____

Higiene pessoal

Estado ☐ Cuidada ☐ Descuidada

Tipo de ajuda ☐ Total ☐ Nenhuma ☐ Parcial _____

Mobilidade

☐ Autônoma ☐ Dependente. Especifique _____

Eliminação

Vesical ☐ Inalterada ☐ Alterada _____

Intestinal ☐ Inalterada ☐ Alterada _____

Visão ☐ Inalterada ☐ Alterada _____

Audição ☐ Inalterada ☐ Alterada _____

Comportamentos Aditivos ☐ Não ☐ Sim ☐

Tipo _____ Quantidade _____

Sexualidade

Utiliza algum método contraceptivo ☐ Não ☐ Sim Qual? _____

Desde quando? _____ Qual a última toma? _____

☐ Problemas declarados Especifique _____

Desde quando? Qual a última toma?

Sono e repouso ☐ Sem alterações ☐ Sono agitado ☐ Sono superficial
☐ Insónia ☐ Inicial ☐ Terminal ☐ Total

☐ Insónia ☐ Inicial ☐ Terminal ☐ Total

Alergias Não ☐ Desconhece ☐ Sim ☐ Quais? _____

Avaliação social

Referenciado para apoio social ☐ Não ☐ Sim Qual o motivo _____

[illegible]

Assinatura Enf. _____

[illegible]

1. _____
2. _____
3. _____

➤ Annex 2 - WHO - ICMHC

International Classification of Mental Health Care

ICMHC

INTERNATIONAL CLASSIFICATION OF MENTAL HEALTH CARE

A tool for describing services providing mental health care

A. de Jong

WHO Collaborating Centre for Research and Training in Mental Health



Department of Social Psychiatry, University of Groningen, Netherlands

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ICMHC

INTERNATIONAL CLASSIFICATION OF MENTAL HEALTH CARE

A tool for describing services providing mental health care

A. de Jong

December 1996

WHO Collaborating Centre, Department of Social Psychiatry, University of
Groningen
P.O.Box 30001, 9700 RB Groningen, the Netherlands

ESTABLISHING AND MAINTAINING PROFESSIONAL RELATIONSHIPS

DESCRIPTION
<p>This modality refers to all activities aimed at involving individuals in need or considered to be in need of professional help in the mental health care process, and at keeping them involved if necessary. This includes:</p> <ul style="list-style-type: none"> ! activities necessary to establish relationships; either on the initiative or request of individuals, mental health professionals, or others (including services, agencies and authorities), and ! activities necessary to maintain relationships; primarily on the initiative of the mental health professionals. <p>Please note:</p> <ul style="list-style-type: none"> □ The activities necessary to establish and maintain professional relationships may in themselves (perhaps as a side-effect) result in improvements in an individual=s mental health and/or living circumstances. This may particularly apply to the field of psychosocial rehabilitation. It should be noted, however, that this modality is limited to activities relating to the relationship between individuals and mental health professionals. All deliberate activities to improve mental health or the individual=s circumstances should be classified elsewhere. □ Administrative procedures (irrespective of whether or not mental health professionals are involved) are not considered to be part of the activities falling under the heading of this modality.
ADDITIONAL REMARKS
<p><i>Psychiatric care</i></p> <p>In general, establishing and maintaining professional relationships will be limited to administrative procedures, making this modality not applicable to psychiatric care. However, home visits may be a more or less regular part of the activities.</p> <p><i>Psychosocial rehabilitation</i></p> <p>Establishing and maintaining professional relationships can be a very time- and energy-consuming activity, that may even require working outside office hours. This may especially apply to homeless or vagrant individuals with a history of mental problems.</p>

EXCLUDES: Activities falling under the headings of the modalities Problem and Functional Assessments, Care Coordination and (Re)educating Basic, Interpersonal and Social Skills.

Home visits as part of assessment procedures or interventions.

RELATED TERMS Client engagement, out-reaching, case-finding.

ESTABLISHING AND MAINTAINING PROFESSIONAL RELATIONSHIPS

Level of specialisation rating scale

Please note that the different elements in these descriptions should **not** be interpreted as being strict criteria, each of which has to be satisfied before a modality can be assessed as having this level of specialization. Rather the whole of the description should be taken as an overall indication of the level of specialization.

HIGH LEVEL OF SPECIALISATION

RATE 3

Activities relate to establishing as well as maintaining professional relationships. Employees are actively involved in reaching out to individuals for both purposes. Home visits will be part of the overall treatment philosophy in this module and will as such be made on a regular basis and in crisis situations.

INTERMEDIATE LEVEL OF SPECIALISATION

RATE 2

Activities relate to establishing and maintaining professional relationships. Employees will be reaching out to individuals. In general, home visits will only be made in crisis situations.

LOW LEVEL OF SPECIALISATION

RATE 1

Activities to establish relationships consist of procedures to select individuals. Criteria for selection are contingent upon the type of care provided by the Module. There are no activities to maintain relationships.

NOT APPLICABLE TO THIS MODULE

RATE 0

Activities to establish and/or maintain relationships are *not* part of the regular activities in this module.

PROBLEM AND FUNCTIONAL ASSESSMENT

DESCRIPTION	
<p>This modality refers to all activities necessary to formulate an initial plan of treatment or rehabilitation, to monitor and (if necessary) to adjust this plan during its implementation. Activities include:</p> <ul style="list-style-type: none"> ! carrying out initial assessments of the individual's psychological, social and somatic problems and (if applicable) of all relevant aspects of the individual's environment, ! the possible use of special diagnostic tools or procedures contingent on the particular aims of the assessments, ! formulating a plan for treatment or rehabilitation consequent upon the results of the assessments, and ! carrying out repeated assessments of the individual's problems and the aspects of the environment to monitor the implementation of the plan for treatment or rehabilitation. <p>Please note:</p> <p><input type="checkbox"/> Activities, relevant to this modality, but carried out by third parties (individuals and/or services not formally related to the Module under consideration) should <u>not</u> be taken into account while making ratings.</p>	
ADDITIONAL REMARKS	
<p><i>Psychiatric care</i></p> <p>Emphasis will usually be on initial assessments, resulting in a psychiatric diagnosis, which will often be formulated according to ICD- or DSM-criteria. The plan for treatment will primarily be focused on the impairments and disabilities, resulting from the psychiatric disorder.</p> <p><i>Psychosocial rehabilitation</i></p> <p>There will be a strong emphasis on the assessment of the individual's skills and strengths and on aspects of his or hers social environment. In addition, the individual's own preferences and the goals he or she wants to achieve will be explicitly taken into account while formulating a plan for rehabilitation. To be able to monitor the implementation of the plan repeated assessments at regular intervals will be carried out frequently.</p>	

INCLUDES	Departments, specializing in assessing groups of patients with specific disorders or problems
	Intake procedures
EXCLUDES	All activities that are part of the actual implementation of the plan for treatment or rehabilitation. See the relevant modalities pertaining to interventions.

PROBLEM AND FUNCTIONAL ASSESSMENT

Level of specialisation rating scale

Please note that the different elements in these descriptions should **not** be interpreted as being strict criteria, each of which has to be satisfied before a modality can be assessed as having this level of specialisation. Rather the whole of the description should be taken as an overall indication of the level of specialisation.

HIGH LEVEL OF SPECIALISATION

RATE 3

As far as initial or repeated assessments are part of the activities within the Module of Care the following applies:

! Initial assessments will be extensive and often aimed at specific problems or disorders. This will require the use of special diagnostic tools or procedures.

! Repeated assessments will be carried out at regular intervals to monitor the implementation of the plan for treatment or rehabilitation.

As a rule, all assessments will be aimed at the individual as well as at the social environment.

INTERMEDIATE LEVEL OF SPECIALIZATION

RATE 2

As far as initial or repeated assessments are part of the activities within the Module of Care the following applies:

! Initial assessments will be carried out using standard diagnostic tools or according to standard procedures.

! Repeated assessments will be carried out infrequently.

Assessments may only be aimed at the individual. Or information on the social environment is only collected as a spin-off in the process of making assessments of the individual.

LOW LEVEL OF SPECIALISATION

RATE 1

Initial assessments will be carried out, but not in all cases. Or the *extent* of the initial assessments may fall below the level of usual, standard practice in mental health care.

Repeated assessments will not be planned, but may be carried out occasionally.

NOT APPLICABLE TO THIS MODULE

RATE 0

Initial assessments are carried out outside the Module of Care or will be carried out only occasionally. Repeated assessments will not be carried out.

CARE COORDINATION

DESCRIPTION	
<p>This modality refers to all activities necessary to guarantee that individuals have access to all required services, provided by the Module of Care and by other institutions or agencies. Employees may act as intermediaries on behalf of individuals or may have the authority to ensure that the required services are provided. These services may be provided simultaneously and/or subsequent to each other.</p> <p>Institutions or agencies include:</p> <ul style="list-style-type: none"> ! other Modules of Care: other in- or outpatient departments in the same mental health care institution or elsewhere, ! other institutions or agencies providing general health care, ! social and other services, that are not regular parts of the mental health care system. <p>Activities relevant to Care Coordination can include:</p> <ul style="list-style-type: none"> ! referring (every activity necessary to ensure continuity of care), ! planning (developing a comprehensive management or treatment plan), ! linking (arranging for services to be provided), and ! monitoring (monitoring and assessing the services delivered). <p>Please note:</p> <p><input type="checkbox"/> This modality pertains to organizational activities only. Sending letters of discharge (or comparable documents) is considered to be part of normal administrative procedures. As such this activity should <u>not</u> be taken into account while rating this modality.</p>	
ADDITIONAL REMARKS	
<p><i>Psychiatric care</i></p> <p>Referring individuals to other (mental health care) services is common practice in psychiatric care. As far as this process is limited to administrative procedures, the activities should not be taken into account. It is, however, possible that to ensure continuity of care (more or less) standardized methods are used that go beyond these administrative procedures.</p> <p><i>Psychosocial rehabilitation</i></p> <p>Since psychosocial rehabilitation often requires cooperation between different services, coordination and integration will be necessary to ensure continuity of care.</p>	

INCLUDES	All organizational activities, necessary to ensure continuity of care.
EXCLUDES	<p>All activities necessary to establish and maintain relationships with individuals. See modality Establishing and Maintaining Professional Relationships.</p> <p>All activities that are part of assessment procedures. See modality Problem and Functional Assessment.</p> <p>All activities that are part of interventions, aimed at the individual and/or his or her living environment. See all relevant modalities.</p>
RELATED TERMS	Organizing continuity of care (aftercare), case management, service-integration and coordination, linking, brokering, advocacy, ensuring continuity of care and access to comprehensive services.

CARE COORDINATION

Level of specialisation rating scale

Please note that the different elements in these descriptions should **not** be interpreted as being strict criteria, each of which has to be satisfied before a modality can be assessed as having this level of specialisation. Rather the whole of the description should be taken as an overall indication of the level of specialisation.

HIGH LEVEL OF SPECIALISATION

RATE 3

Developing a comprehensive management or treatment plan for individual patients and monitoring its progress is part of the activities. In addition, employees will have the authority to ensure the implementation of all or most of the elements in this plan for individual cases.

INTERMEDIATE LEVEL OF SPECIALISATION

RATE 2

Developing a comprehensive management or treatment plan for individual patients and monitoring its progress is part of the activities. However, employees will have no authority to ensure the implementation of those elements of this plan that are to be carried out outside the Module of Care itself.

LOW LEVEL OF SPECIALISATION

RATE 1

Care coordination is in effect limited to the process of referring individuals to other Modules of Care or other services. However, activities go beyond sending letters of discharge. Standard procedures to ensure continuity of care will be used to a certain extent.

NOT APPLICABLE TO THIS MODULE

RATE 0

Activities relevant to this modality are not provided (with the exception of sending letters of discharge).

GENERAL HEALTH CARE

DESCRIPTION
<p>This modality refers to all activities necessary to provide general health care to individuals in treatment in the Module of Care.</p> <p>Please note:</p> <ul style="list-style-type: none"> <input type="checkbox"/> It is not mandatory for the general health care to be provided within the physical location of the Module of Care itself. It is mandatory, however, that all general health care is provided under the responsibility of the Module of Care. <input type="checkbox"/> This modality refers to activities that are provided within the framework of mental health care only. General health care that does not come within the area of responsibility of the Module of Care should not be taken into account.
ADDITIONAL REMARKS
<p><i>Psychiatric care</i></p> <p>The provision of general health care within the framework of mental health care will particularly pertain to individuals who are (temporarily) suffering from psychiatric as well as somatic impairments.</p> <p><i>Psychosocial rehabilitation</i></p> <p>Although the physical health of individuals with long-standing mental health problems may often leave much to be desired, providing general health care will not usually be part of the services, provided in the framework of psychosocial rehabilitation.</p>

INCLUDES	<p>All necessary assessments in as far as these are carried out by employees of this Module or at least under their responsibility.</p> <p>All activities carried out by third party professionals but coming within the area of responsibility of the Module of Care.</p>
EXCLUDES	<p>All activities pertaining to providing for individuals insufficiently capable of managing for themselves. See modality Taking over Activities of Daily Living.</p> <p>Assessments and all other activities pertaining to the prescription and use of psychopharmacological medication. See modality Problem and Functional Assessment.</p> <p>Treatment taking place elsewhere (e.g., temporary transfers to units for general health care or referrals to a general practitioner outside the Module).</p> <p>Activities on the organizational level necessary to provide general health care. See modality Care Coordination.</p>

GENERAL HEALTH CARE
Level of specialisation rating scale

Please note that the different elements in these descriptions should **not** be interpreted as being strict criteria, each of which has to be satisfied before a modality can be assessed as having this level of specialisation. Rather the whole of the description should be taken as an overall indication of the level of specialisation.

HIGH LEVEL OF SPECIALISATION

RATE 3

General health care as provided by medical professionals (including nurses) to individuals suffering from psychiatric as well as somatic problems. The somatic problems should be of a severe or possibly even life-threatening nature. Nurses may have been specially trained in caring for this group of patients. The efforts and/or supervision of medical specialists will regularly be required.

INTERMEDIATE LEVEL OF SPECIALISATION

RATE 2

General health care as provided by medical professionals (including nurses) to individuals suffering from psychiatric as well as somatic problems. The somatic problems should be mild. The efforts of medical specialists may occasionally be required.

LOW LEVEL OF SPECIALISATION

RATE 1

General health care provided is comparable to health care as provided by general practitioners.

NOT APPLICABLE TO THIS MODULE

RATE 0

General health care is not or only occasionally provided.

TAKING OVER ACTIVITIES OF DAILY LIVING

DESCRIPTION
<p>This modality refers to all activities necessary to provide for those individuals who are not (or not completely) capable to manage for themselves. More specifically, employees will take over activities of daily living, such as washing, dressing, cleaning, cooking, shopping, and so on. The foremost reason for this is to avoid self-neglect in individuals, which, in extreme cases, may lead to life-threatening situations.</p> <p>Please note:</p> <p>□ In units of psychiatric hospitals (or comparable Modules of Care) taking over some activities of daily living (notably the provision of meals, cleaning, household chores in general) will be part of the regular duties of employees. This will apply to all individuals being cared for, even though they may perfectly be able to manage for themselves. In general, this will lead to a rating of low level on the Level of Specialisation Rating Scale.</p>
ADDITIONAL REMARKS
<p><i>Psychiatric care</i></p> <p>This modality particularly pertains to units or departments in psychiatric hospital for multiple handicapped, elderly and/or chronic patients.</p> <p><i>Psychosocial rehabilitation</i></p> <p>Since in most cases activities relating to providing for individuals who cannot manage for themselves will be limited to in-patient settings, this modality will usually not be part of psychosocial rehabilitation.</p>

INCLUDES	Activities as mentioned above carried out by employees working in homes for sheltered living.
EXCLUDES	<p>All activities pertaining to the provision of general health care.</p> <p>All activities aimed at teaching individuals to reach a higher level of self-management.</p>

TAKING OVER ACTIVITIES OF DAILY LIVING
Level of specialisation rating scale

Please note that the different elements in these descriptions should **not** be interpreted as being strict criteria, each of which has to be satisfied before a modality can be assessed as having this level of specialisation. Rather the whole of the description should be taken as an overall indication of the level of specialisation.

HIGH LEVEL OF SPECIALISATION

RATE 3

Activities of daily living are taken over to a large extent. It will

! pertain to almost all individuals, served by the Module, and

! cover almost the entire range of activities of daily living.

Taking over these activities will be necessary to avoid severe self-neglect, potentially resulting in life-threatening situations. This will apply to most of the individuals, served by the Module.

INTERMEDIATE LEVEL OF SPECIALISATION

RATE 2

Activities of daily living are taken over. It will

! pertain to all individuals, served by the Module, or

! cover most of the activities of daily living.

Taking over these activities may be necessary to avoid self-neglect. This will apply to at least some of the individuals, served by the Module.

LOW LEVEL OF SPECIALISATION

RATE 1

Activities of daily living are taken over to a limited extent. It will

! pertain to only a small number of the individuals, served by the Module, or

! be limited to a narrow range of activities.

NOT APPLICABLE TO THIS MODULE

RATE 0

Activities of daily living are not taken over by the Module of Care.

PSYCHOPHARMACOLOGICAL AND OTHER SOMATIC INTERVENTIONS

DESCRIPTION
<p>This modality refers to all activities concerning the use of psychopharmacological drugs and other somatic interventions.</p> <p>Activities pertaining to psychopharmacological drugs include:</p> <ul style="list-style-type: none"> ! prescribing the drugs, ! monitoring the therapeutic and adverse effects of the prescribed (combinations of) drugs, and ! subsequent adjustments of prescriptions. <p>Other somatic interventions include electro-convulsive therapy, sleep deprivation, and so on.</p> <p>Please note:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The use of psychopharmacological drugs should only be rated if employees of the Module of Care are directly involved in their prescription and/or control. <input type="checkbox"/> The application of interventions other than psychopharmacological drugs will require profound assessment and the availability of well-trained personnel. This will automatically lead to the highest rating on the Level of Specialisation Rating Scale.
ADDITIONAL REMARKS
<p><i>Psychiatric care</i></p> <p>Prescription of drugs is common practice. Monitoring their (anti-)therapeutic effects is less common and may require the availability of laboratory and other assessment techniques. The application of other somatic interventions (electro-convulsive therapy in particular) will normally be carried out in Modules, that are especially equipped for that purpose.</p> <p><i>Psychosocial rehabilitation</i></p> <p>The use of somatic interventions will generally be limited to the use of psychopharmacological drugs.</p>

INCLUDES	Modules of Care dedicated to the application of specific somatic interventions.
EXCLUDES	<p>Prescription and control of psychopharmacological drugs by third party professionals not linked to the Module of Care.</p> <p>Procedures of assessment preceding the application of interventions. See modality Problem and Functional Assessment.</p> <p>All activities pertaining to general health care See modality General Health Care.</p>
RELATED TERMS	Biological-psychiatric interventions and techniques.

PSYCHOPHARMACOLOGICAL AND OTHER SOMATIC INTERVENTIONS

Level of specialisation rating scale

Please note that the different elements in these descriptions should **not** be interpreted as being strict criteria, each of which has to be satisfied before a modality can be assessed as having this level of specialisation. Rather the whole of the description should be taken as an overall indication of the level of specialisation.

HIGH LEVEL OF SPECIALISATION

RATE 3

Somatic interventions like ECT, sleep deprivation, and so on, are made available. Although these procedures should not be taken into account while rating this modality, thorough assessments will always precede the application of the interventions. If psychopharmacological drugs are prescribed, the therapeutic results will be monitored closely. For **all** interventions at this level of specialisation the availability of special equipment **and** the presence of well-trained personnel is required.

INTERMEDIATE LEVEL OF SPECIALISATION

RATE 2

The prescription of psychopharmacological drugs is closely monitored according to well-defined procedures. The application of specific techniques (e.g. laboratory tests to determine blood levels) in these procedures is a prerequisite for this rating.

LOW LEVEL OF SPECIALISATION

RATE 1

Psychopharmacological drugs will be prescribed. Therapeutic results will be monitored, often in the context of the on-going provision of other mental health care modalities. Apart from perhaps an initial assessment at the start of prescription, the use of specific techniques (e.g. laboratory tests to determine blood levels) will not be necessary.

NOT APPLICABLE TO THIS MODULE

RATE 0

Psychopharmacological drugs will not be prescribed by employees of this Module of Care. Drugs may, however, be prescribed and/or monitored by third party professionals.

PSYCHOLOGICAL INTERVENTIONS

DESCRIPTION	
<p>This modality refers to all interventions that are primarily aimed at facilitating changes in the ways in which individuals perceive and understand their emotions, thoughts and behavior. This presupposes the individual's ability and willingness for introspection. As a rule, these interventions will be based on theoretical models. Interventions may be aimed at individuals or at groups of individuals.</p> <p>In rating this modality the following should be considered:</p> <ul style="list-style-type: none"> ! the level of training and/or education employees need in order to apply the interventions, and ! the number of different interventions that can be provided by the Module. <p>Please note:</p> <ul style="list-style-type: none"> <input type="checkbox"/> There is a practical and theoretical overlap between this modality and the modality (Re)educating Skills. It may, therefore, sometimes be difficult to decide under which modality activities should be classified. <input type="checkbox"/> The following rule of thumb may be helpful: Psychological Interventions: primarily based on introspection, (Re)educating Skills: primarily aimed at coping with existing impairments and disabilities. 	
ADDITIONAL REMARKS	
<p><i>Psychiatric care</i></p> <p>The application of psychological interventions ranges from supportive talks, involving no more than two people, to treatment in therapeutic communities, where a wide range of therapies is provided by highly-skilled mental health professionals.</p> <p><i>Psychosocial rehabilitation</i></p> <p>Psychological interventions will be less frequently applied, perhaps in favour of the kind of interventions, that fall the under modality (Re)educating Skills.</p>	

INCLUDES	All forms of individual or group psychotherapy, psychomotor therapy, creative therapy, and so on.
EXCLUDES	All forms of skills training. See the modality (Re)educating skills.

PSYCHOLOGICAL INTERVENTIONS

Level of specialisation rating scale

Please note that the different elements in these descriptions should **not** be interpreted as being strict criteria, each of which has to be satisfied before a modality can be assessed as having this level of specialisation. Rather the whole of the description should be taken as an overall indication of the level of specialisation.

HIGH LEVEL OF SPECIALISATION

RATE 3

Psychological interventions will generally be based on well-defined theoretical models. Their application requires (extensive) training or education. A wide range of different interventions can be provided by the employees of the Module, dependent upon the needs of the individuals in care.

INTERMEDIATE LEVEL OF SPECIALISATION

RATE 2

Psychological interventions will generally be based on well-defined theoretical models. Their application requires (extensive) training or education. A limited range of different interventions can be provided by the employees of the Module, dependent upon the needs of the individuals in care.

LOW LEVEL OF SPECIALISATION

RATE 1

Psychological interventions will generally be limited to supportive talks and giving advice. Employees may require some training or education for their application. There are, however, no clear-cut theoretical models underlying these interventions.

NOT APPLICABLE TO THIS MODULE

RATE 0

Psychological interventions are not provided in this Module of Care.

(RE)EDUCATING BASIC, INTERPERSONAL AND SOCIAL SKILLS

DESCRIPTION	
<p>This modality refers to all interventions that are primarily aimed at helping individuals to cope with their impairments and personal disabilities. In general, this presupposes acceptance (temporarily or permanently) of the existence of these impairments and disabilities and focuses on alleviating their consequences in everyday life. Interventions will often be aimed at improving the individual's skills in coping with symptoms, self-management, using amenities and social interaction, etc. These interventions will be based on more or less well-defined theoretical models, often centred on cognitive deficits or the stress-vulnerability hypothesis.</p> <p>In rating this modality the following should be considered:</p> <ul style="list-style-type: none"> ! the level of training and/or education employees need to apply the interventions, and ! the number of different interventions that can be provided by the Module. <p>Please note:</p> <ul style="list-style-type: none"> <input type="checkbox"/> There is a practical and theoretical overlap between this modality and the modality Psychological Interventions. It may, therefore, sometimes be difficult to decide under which modality activities should be classified. <input type="checkbox"/> The following rule of thumb may be helpful: Psychological Interventions: primarily based on introspection, (Re)educating Skills: primarily aimed at coping with existing impairments and disabilities. <input type="checkbox"/> There may also be an overlap with the modality Establishing and Maintaining Professional Relationships. Especially in the field of psychosocial rehabilitation maintaining relationships may in itself lead to improvements in mental health. It should be noted that only deliberate attempts to improve the individual's situation, based on more or less well-defined theoretical models should be considered in rating the present modality. 	
ADDITIONAL REMARKS	
<p><i>Psychiatric care</i></p> <p>Interventions aimed at (re)educating basic, personal and social skills will be less frequently applied, perhaps in favour of the kind of interventions, falling under modality Psychological Interventions.</p> <p><i>Psychosocial rehabilitation</i></p> <p>Since psychosocial rehabilitation presupposes the existence of impairments and disabilities, interventions aimed at (re)education of basic, interpersonal and/or social skills will often figure prominently in plans of rehabilitation.</p>	

INCLUDES

All forms of skills training.

EXCLUDES

All forms of individual or group psychotherapy, psychomotor therapy, creative therapy, etc.

(RE)EDUCATING BASIC, INTERPERSONAL AND SOCIAL SKILLS
Level of specialisation rating scale

Please note that the different elements in these descriptions should **not** be interpreted as being strict criteria, each of which has to be satisfied before a modality can be assessed as having this level of specialisation. Rather the whole of the description should be taken as an overall indication of the level of specialisation.

HIGH LEVEL OF SPECIALISATION

RATE 3

Interventions will generally be based on well-defined theoretical models. Their application requires (extensive) training or education. A wide range of different interventions can be provided by the employees of the Module, dependent upon the needs of the individuals in care.

INTERMEDIATE LEVEL OF SPECIALISATION

RATE 2

Interventions will generally be based on well-defined theoretical models. Their application requires (extensive) training or education. A limited range of different interventions can be provided by the employees of the Module, dependent upon the needs of the individuals in care.

LOW LEVEL OF SPECIALISATION

RATE 1

Interventions will generally be limited to (re)educating basic skills such as washing, dressing, preparing meals, budgeting, etc. Employees may require some training or education for their application. There are, however, no clear-cut theoretical models underlying these interventions.

NOT APPLICABLE TO THIS MODULE

RATE 0

Interventions to (re)educating basic, interpersonal and social skills are not provided by this Module.

INTERVENTIONS RELATED TO DAILY ACTIVITIES

DESCRIPTION
<p>This modality refers to all activities aimed at helping and/or teaching individuals to spend their days in ways that are worthwhile to them. In choosing these ways, care should be taken that the individual=s present or intended daily activities</p> <ul style="list-style-type: none"> ! are personally satisfying, ! have an intrinsic social value, and ! will help them overcome their social handicaps. <p>Daily activities will depend on the individual's impairments, disabilities and living environment. Included are such diverse activities as participating in occupational therapy in a psychiatric hospital, leisure time activities, participating in social activities in the community, and getting an education or having a regular job. Providing daily activities may be part of the Module's services. Employees may act as intermediaries on behalf of the individual in finding appropriate daily activities. They may also be involved in preparing the individual for future activities, for example by providing dedicated training programmes.</p> <p>In rating this modality the following should be considered:</p> <ul style="list-style-type: none"> ! the level of training and/or education employees need to apply the interventions, and ! the number of different interventions that can be provided by the Module. <p>Please note:</p> <p><input type="checkbox"/> Activities, relevant to this modality, but provided by third parties should <u>not</u> be taken into account while making ratings.</p>
ADDITIONAL REMARKS
<p><i>Psychiatric care</i></p> <p>Providing daily activities may be limited to occupational therapy. Arranging and/or offering sheltered employment, however, may also be part of the regular activities in a Module.</p> <p><i>Psychosocial rehabilitation</i></p> <p>Helping individuals to increase their abilities and/or possibilities to spend their days in ways that are worthwhile is a major issue in psychosocial rehabilitation. This will particularly pertain to getting a regular job or an education.</p>

INCLUDES	Occupational therapy, vocational training, providing sheltered or transitional employment opportunities, all activities that help individuals to (prepare to) get an education
EXCLUDES	All forms of skills training

INTERVENTIONS RELATED TO DAILY ACTIVITIES

Level of specialisation rating scale

Please note that the different elements in these descriptions should **not** be interpreted as being strict criteria, each of which has to be satisfied before a modality can be assessed as having this level of specialisation. Rather the whole of the description should be taken as an overall indication of the level of specialisation.

HIGH LEVEL OF SPECIALISATION

RATE 3

To apply the interventions employees will require (extensive) training or education. A wide range of different interventions can be provided by the Module, dependent upon the needs of the individuals in care.

INTERMEDIATE LEVEL OF SPECIALISATION

RATE 2

To apply the interventions employees will require training or education. A limited range of different interventions can be provided by the employees of the Module, dependent upon the needs of the individuals in care.

LOW LEVEL OF SPECIALISATION

RATE 1

A limited program of (acquiring) daily activities is offered to the individuals in care in the Module. This program may not be explicitly aimed at increasing the abilities and/or possibilities of the individuals to spend their day in ways that are meaningful to them. Training or education may not necessarily be required.

NOT APPLICABLE TO THIS MODULE

RATE 0

Interventions aimed at helping and/or teaching individuals to spend their day are not provided by this Module.

INTERVENTIONS AIMED AT FAMILY, RELATIVES AND OTHERS

DESCRIPTION
<p>This modality refers to all activities aimed at maximizing support in the living environment of the individual. Interventions may be aimed at giving support to significant others (in particular to the individual's family, but also to neighbours, friends, colleagues, etc.), providing them with information about the individual's disorder and consequent behaviour, and teaching them to deal with the individual's impairments, disabilities, and handicaps.</p> <p>In rating this modality the following should be considered:</p> <ul style="list-style-type: none">! the level of training and/or education employees need to apply the interventions, and! the number of different interventions that can be provided by the Module.
ADDITIONAL REMARKS
<p><i>Psychiatric care</i></p> <p><i>Psychosocial rehabilitation</i></p> <p>A great number of activities fall under the heading of this modality, ranging from giving general information about the individual's illness to neighbours, colleagues, etc., to providing support to the individual's family, using highly sophisticated methods.</p>

INCLUDES Psycho-education of the family or significant others

INTERVENTIONS AIMED AT FAMILY, RELATIVES AND OTHERS
Level of specialisation rating scale

Please note that the different elements in these descriptions should **not** be interpreted as being strict criteria, each of which has to be satisfied before a modality can be assessed as having this level of specialisation. Rather the whole of the description should be taken as an overall indication of the level of specialisation.

HIGH LEVEL OF SPECIALISATION

RATE 3

To apply the interventions employees will require training or education. A wide range of different interventions can be provided by the employees of the Module, dependent upon the needs of the individuals in care.

INTERMEDIATE LEVEL OF SPECIALISATION

RATE 2

To apply the interventions employees will require training or education. A limited range of different interventions can be provided by the employees of the Module, dependent upon the needs of the individuals in care.

LOW LEVEL OF SPECIALISATION

RATE 1

Interventions will generally be limited to providing support for people in the social environment of the individual. Some training or education may be required to apply these interventions.

NOT APPLICABLE TO THIS MODULE

RATE 0

Interventions aimed at family, relatives and others are not provided by this Module.

Annex 3 - VSSS

Verona Service Satisfaction Scale



Escala de Verona para Avaliação da Satisfação com os Serviços de Psiquiatria

**NESTE QUESTIONÁRIO PRETENDE-SE CONHECER A SUA EXPERIÊNCIA
DURANTE O ÚLTIMO ANO COM O SERVIÇO DE PSIQUIATRIA DE :**

.....

É muito importante que a sua resposta seja sincera; exprima livremente a sua opinião, seja ela qual for.

Estamos particularmente interessados em conhecer as suas críticas e os aspectos negativos que encontrou no seu contacto com o Serviço.

Todas as suas respostas serão tratadas com a máxima confidencialidade.

Ninguém, incluindo técnicos do Serviço ou os seus familiares, virá a ter conhecimento das opiniões expressas nas suas respostas.

Por favor, peça ajuda ao entrevistador caso qualquer questão não esteja clara ou caso tenha dificuldade em preencher o questionário.

Leia atentamente todas as perguntas e demore o que for necessário antes de responder.

Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !

Versão Portuguesa: Miguel Xavier, J.M.Caldas de Almeida

Departamento de Saúde Mental – Faculdade de Ciências Médicas de Lisboa

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Verona Service Satisfaction Scale, 1994

NAS PRÓXIMAS PÁGINAS SERÃO DESTACADOS VÁRIOS
ASPECTOS DA SUA EXPERIÊNCIA COM O SERVIÇO
PSIQUIÁTRICO DE
DURANTE O ÚLTIMO ANO.

Deverá indicar qual a sua impressão global sobre os vários aspectos, assinalando com um X a resposta que melhor descreve a sua experiência com o Serviço Psiquiátrico em questão, no último ano.

As respostas possíveis são as seguintes:

1. Péssima
2. Predominantemente insatisfatória
3. Razoável
4. Predominantemente satisfatória
5. Óptima

Por favor, leia atentamente cada uma das seguintes frases e indique a resposta que melhor descreve a sua experiência com o Serviço de **no último ano**

Qual a sua impressão global sobre

1. A eficácia do serviço em ajudá-lo(a) a enfrentar os seus problemas

1. Péssima 2. Predominantemente insatisfatória 3. Razoável 4. Predominantemente satisfatória 5. Óptima

2. O comportamento e disponibilidade do pessoal auxiliar (ex. secretaria, atendimento telefónico)

5. Óptima 4. Predominantemente satisfatória 3. Razoável 2. Predominantemente insatisfatória 1. Péssima

3. A competência e profissionalismo dos psiquiatras e psicólogos

1. Péssima 2. Predominantemente insatisfatória 3. Razoável 4. Predominantemente satisfatória 5. Óptima

4. O aspecto, disposição e funcionalidade das instalações (ex. sala de espera, gabinetes médicos)

5. Óptima 4. Predominantemente satisfatória 3. Razoável 2. Predominantemente insatisfatória 1. Péssima

5. A capacidade dos psiquiatras e psicólogos para escutarem e compreenderem os seus problemas

1. Péssima 2. Predominantemente insatisfatória 3. Razoável 4. Predominantemente satisfatória 5. Óptima

6. O comportamento e disponibilidade dos psiquiatras e psicólogos

5. Óptima 4. Predominantemente satisfatória 3. Razoável 2. Predominantemente insatisfatória 1. Péssima

7. O respeito pelas marcações e pontualidade dos técnicos nas consultas que lhe eram marcadas

1. Péssima 2. Predominantemente insatisfatória 3. Razoável 4. Predominantemente satisfatória 5. Óptima

Leia atentamente todas as perguntas e demore o que for necessário antes de responder.

Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !

Por favor, leia atentamente cada uma das seguintes frases e indique a resposta que melhor descreve a sua experiência com o Serviço de **no último ano**

Qual a sua impressão global sobre

8. As despesas do tratamento que ficam a seu cargo (ex. medicamentos, consultas, exames, etc.)

5. Ótima 4. Predominantemente satisfatória 3. Razoável 2. Predominantemente insatisfatória 1. Péssima

9. A eficácia do Serviço em ajudá-lo(a) a estar bem e a prevenir a doença

1. Péssima 2. Predominantemente insatisfatória 3. Razoável 4. Predominantemente satisfatória 5. Ótima

10. A confidencialidade (segredo profissional) e o respeito pelos seus direitos

5. Ótima 4. Predominantemente satisfatória 3. Razoável 2. Predominantemente insatisfatória 1. Péssima

11. A quantidade de ajuda que tem recebido

1. Péssima 2. Predominantemente insatisfatória 3. Razoável 4. Predominantemente satisfatória 5. Ótima

12. A explicação fornecida acerca dos métodos de tratamento e das técnicas utilizadas

5. Ótima 4. Predominantemente satisfatória 3. Razoável 2. Predominantemente insatisfatória 1. Péssima

13. A eficácia do Serviço em melhorar os seus sintomas

1. Péssima 2. Predominantemente insatisfatória 3. Razoável 4. Predominantemente satisfatória 5. Ótima

14. A resposta do Serviço de Urgência em situações que ocorrem durante o dia (dias úteis)

5. Ótima 4. Predominantemente satisfatória 3. Razoável 2. Predominantemente insatisfatória 1. Péssima

15. A resposta do Serviço de Urgência em situações que ocorrem de noite ou em feriados

1. Péssima 2. Predominantemente insatisfatória 3. Razoável 4. Predominantemente satisfatória 5. Ótima

Leia atentamente todas as perguntas e demore o que for necessário antes de responder.

Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !

Por favor, leia atentamente cada uma das seguintes frases e indique a resposta que melhor descreve a sua experiência com o Serviço de **no último ano**

Qual a sua impressão global sobre

16. Os cuidados e a clareza na comunicação dos psiquiatras e psicólogos

- | | | | | |
|----------|-----------------------------------|-------------|-------------------------------------|------------|
| 5. Ótima | 4. Predominantemente satisfatória | 3. Razoável | 2. Predominantemente insatisfatória | 1. Péssima |
|----------|-----------------------------------|-------------|-------------------------------------|------------|

17. A capacidade dos psiquiatra e psicólogos colaborarem com o seu médico de família ou com outro médico especialista, se necessário

- | | | | | |
|------------|-------------------------------------|-------------|-----------------------------------|----------|
| 1. Péssima | 2. Predominantemente insatisfatória | 3. Razoável | 4. Predominantemente satisfatória | 5. Ótima |
|------------|-------------------------------------|-------------|-----------------------------------|----------|

18. A capacidade dos técnicos de colaborarem entre si (caso tenha contactado com mais de um grupo de técnicos, tais como médicos, enfermeiros, assistentes sociais, etc.)

- | | | | | |
|----------|-----------------------------------|-------------|-------------------------------------|------------|
| 5. Ótima | 4. Predominantemente satisfatória | 3. Razoável | 2. Predominantemente insatisfatória | 1. Péssima |
|----------|-----------------------------------|-------------|-------------------------------------|------------|

19. A informação que lhe foi fornecida sobre os programas e tratamentos prestados pelo Serviço

- | | | | | |
|------------|-------------------------------------|-------------|-----------------------------------|----------|
| 1. Péssima | 2. Predominantemente insatisfatória | 3. Razoável | 4. Predominantemente satisfatória | 5. Ótima |
|------------|-------------------------------------|-------------|-----------------------------------|----------|

20. O tipo de serviços e cuidados oferecidos

- | | | | | |
|----------|-----------------------------------|-------------|-------------------------------------|------------|
| 5. Ótima | 4. Predominantemente satisfatória | 3. Razoável | 2. Predominantemente insatisfatória | 1. Péssima |
|----------|-----------------------------------|-------------|-------------------------------------|------------|

21. Os serviços e cuidados que recebeu, na generalidade

- | | | | | |
|------------|-------------------------------------|-------------|-----------------------------------|----------|
| 1. Péssima | 2. Predominantemente insatisfatória | 3. Razoável | 4. Predominantemente satisfatória | 5. Ótima |
|------------|-------------------------------------|-------------|-----------------------------------|----------|

22. A competência e profissionalismo dos enfermeiros e assistentes sociais

- | | | | | |
|----------|-----------------------------------|-------------|-------------------------------------|------------|
| 5. Ótima | 4. Predominantemente satisfatória | 3. Razoável | 2. Predominantemente insatisfatória | 1. Péssima |
|----------|-----------------------------------|-------------|-------------------------------------|------------|

*Leia atentamente todas as perguntas e demore o que for necessário antes de responder.
Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !*

Verona Service Satisfaction Scale, 1994

Por favor, leia atentamente cada uma das seguintes frases e indique a resposta que melhor descreve a sua experiência com o Serviço de **no último ano**

Qual a sua impressão global sobre

23. Os conselhos dados aos seus familiares mais próximos sobre a maneira de o(a) ajudar

- | | | | | |
|------------|-------------------------------------|-------------|-----------------------------------|-----------|
| 1. Péssima | 2. Predominantemente insatisfatória | 3. Razoável | 4. Predominantemente satisfatória | 5. Óptima |
|------------|-------------------------------------|-------------|-----------------------------------|-----------|

24. A eficácia do Serviço em ajudá-lo a conhecer e compreender melhor os seus problemas

- | | | | | |
|-----------|-----------------------------------|-------------|-------------------------------------|------------|
| 5. Óptima | 4. Predominantemente satisfatória | 3. Razoável | 2. Predominantemente insatisfatória | 1. Péssima |
|-----------|-----------------------------------|-------------|-------------------------------------|------------|

25. O comportamento e disponibilidade dos enfermeiros e assistentes sociais

- | | | | | |
|------------|-------------------------------------|-------------|-----------------------------------|-----------|
| 1. Péssima | 2. Predominantemente insatisfatória | 3. Razoável | 4. Predominantemente satisfatória | 5. Óptima |
|------------|-------------------------------------|-------------|-----------------------------------|-----------|

26. A eficácia do Serviço em melhorar a relação entre si e os seus familiares mais próximos

- | | | | | |
|-----------|-----------------------------------|-------------|-------------------------------------|------------|
| 5. Óptima | 4. Predominantemente satisfatória | 3. Razoável | 2. Predominantemente insatisfatória | 1. Péssima |
|-----------|-----------------------------------|-------------|-------------------------------------|------------|

27. A eficácia do Serviço em ajudar os seus familiares mais próximos a conhecer e compreender melhor os problemas que você tem

- | | | | | |
|------------|-------------------------------------|-------------|-----------------------------------|-----------|
| 1. Péssima | 2. Predominantemente insatisfatória | 3. Razoável | 4. Predominantemente satisfatória | 5. Óptima |
|------------|-------------------------------------|-------------|-----------------------------------|-----------|

28. O conhecimento por parte dos enfermeiros acerca dos seus problemas actuais e passados

- | | | | | |
|-----------|-----------------------------------|-------------|-------------------------------------|-------------|
| 5. Óptima | 4. Predominantemente satisfatória | 3. Razoável | 2. Predominantemente insatisfatória | 1. Muito má |
|-----------|-----------------------------------|-------------|-------------------------------------|-------------|

29. A informação que lhe foi fornecida sobre o diagnóstico e possível evolução dos seus problemas

- | | | | | |
|------------|-------------------------------------|-------------|-----------------------------------|-----------|
| 1. Péssima | 2. Predominantemente insatisfatória | 3. Razoável | 4. Predominantemente satisfatória | 5. Óptima |
|------------|-------------------------------------|-------------|-----------------------------------|-----------|

Leia atentamente todas as perguntas e demore o que for necessário antes de responder.

Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !

Por favor, leia atentamente cada uma das seguintes frases e indique a resposta que melhor descreve a sua experiência com o Serviço de **no último ano**

Qual a sua impressão global sobre

30. A capacidade dos psiquiatras e psicólogos de escutarem e compreenderem as preocupações dos seus familiares mais próximos relativamente a si

- | | | | | |
|----------|-----------------------------------|-------------|-------------------------------------|------------|
| 5. Ótima | 4. Predominantemente satisfatória | 3. Razoável | 2. Predominantemente insatisfatória | 1. Péssima |
|----------|-----------------------------------|-------------|-------------------------------------|------------|

31. A eficácia do Serviço em melhorar a relação entre si e os seus conhecidos (ex. amigos, vizinhos, colegas de trabalho)

- | | | | | |
|------------|-------------------------------------|-------------|-----------------------------------|----------|
| 1. Péssima | 2. Predominantemente insatisfatória | 3. Razoável | 4. Predominantemente satisfatória | 5. Ótima |
|------------|-------------------------------------|-------------|-----------------------------------|----------|

32. A informação fornecida aos seus familiares mais próximos sobre o diagnóstico e possível evolução do seu problema

- | | | | | |
|----------|-----------------------------------|-------------|-------------------------------------|------------|
| 5. Ótima | 4. Predominantemente satisfatória | 3. Razoável | 2. Predominantemente insatisfatória | 1. Péssima |
|----------|-----------------------------------|-------------|-------------------------------------|------------|

33. A clareza das indicações recebidas no Serviço sobre o que fazer entre uma consulta e outra

- | | | | | |
|------------|-------------------------------------|-------------|-----------------------------------|----------|
| 1. Péssima | 2. Predominantemente insatisfatória | 3. Razoável | 4. Predominantemente satisfatória | 5. Ótima |
|------------|-------------------------------------|-------------|-----------------------------------|----------|

34. A eficácia do Serviço em ajudá-lo a cuidar melhor de si próprio (ex. higiene, alimentação)

- | | | | | |
|----------|-----------------------------------|-------------|-------------------------------------|------------|
| 5. Ótima | 4. Predominantemente satisfatória | 3. Razoável | 2. Predominantemente insatisfatória | 1. Péssima |
|----------|-----------------------------------|-------------|-------------------------------------|------------|

35. Os cuidados e a clareza na comunicação dos enfermeiros e assistentes sociais

- | | | | | |
|------------|-------------------------------------|-------------|-----------------------------------|----------|
| 1. Péssima | 2. Predominantemente insatisfatória | 3. Razoável | 4. Predominantemente satisfatória | 5. Ótima |
|------------|-------------------------------------|-------------|-----------------------------------|----------|

36. A eficácia do Serviço em ajudar os seus familiares mais próximos a lidar melhor com os problemas que você tem

- | | | | | |
|----------|-----------------------------------|-------------|-------------------------------------|------------|
| 5. Ótima | 4. Predominantemente satisfatória | 3. Razoável | 2. Predominantemente insatisfatória | 1. Péssima |
|----------|-----------------------------------|-------------|-------------------------------------|------------|

*Leia atentamente todas as perguntas e demore o que for necessário antes de responder.
Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !*

Verona Service Satisfaction Scale, 1994

Por favor, leia atentamente cada uma das seguintes frases e indique a resposta que melhor descreve a sua experiência com o Serviço de **no último ano**

Qual a sua impressão global sobre

37. A capacidade dos enfermeiros e assistentes sociais de escutarem e compreenderem os seus problemas

- | | | | | |
|------------|-------------------------------------|-------------|-----------------------------------|-----------|
| 1. Péssima | 2. Predominantemente insatisfatória | 3. Razoável | 4. Predominantemente satisfatória | 5. Óptima |
|------------|-------------------------------------|-------------|-----------------------------------|-----------|

38. A eficácia do Serviço em ajudá-lo a melhorar a sua capacidade de trabalho

- | | | | | |
|-----------|-----------------------------------|-------------|-------------------------------------|------------|
| 5. Óptima | 4. Predominantemente satisfatória | 3. Razoável | 2. Predominantemente insatisfatória | 1. Péssima |
|-----------|-----------------------------------|-------------|-------------------------------------|------------|

39. A ajuda recebida para diminuir os efeitos secundários e indesejáveis dos medicamentos

- | | | | | |
|------------|-------------------------------------|-------------|-----------------------------------|-----------|
| 1. Péssima | 2. Predominantemente insatisfatória | 3. Razoável | 4. Predominantemente satisfatória | 5. Óptima |
|------------|-------------------------------------|-------------|-----------------------------------|-----------|

40. A continuidade com que tem sido seguido pelo mesmo técnico (médico/psicólogo)

- | | | | | |
|-----------|-----------------------------------|-------------|-------------------------------------|------------|
| 5. Óptima | 4. Predominantemente satisfatória | 3. Razoável | 2. Predominantemente insatisfatória | 1. Péssima |
|-----------|-----------------------------------|-------------|-------------------------------------|------------|

Leia atentamente todas as perguntas e demore o que for necessário antes de responder.

Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !

Por favor, leia atentamente cada uma das seguintes frases e indique a resposta que melhor descreve a sua experiência com o Serviço de **no último ano**

41. Neste último ano, foram-lhe receitados medicamentos neste Serviço ?

- SIM** (se a resposta foi SIM, responda à seguinte pergunta):
- Qual a sua impressão global sobre os medicamentos que lhe foram receitados ?
5. Ótima
 4. Predominantemente satisfatória
 3. Razoável
 2. Predominantemente insatisfatória
 1. Péssima
- NÃO** (se a resposta foi NÃO, responda à seguinte pergunta):
- Teria desejado que lhe tivessem sido receitados medicamentos ?
6. NÃO 7. NÃO SEI 8. SIM

42. Neste último ano, tem sido ajudado pelos vários técnicos do Serviço a adquirir e a melhorar algumas capacidades úteis para a sua vida social e de trabalho (ex. conseguir ir a repartições públicas, fazer as tarefas domésticas, sentir-se bem e à vontade na companhia de familiares e de conhecidos) ?

- SIM** (se a resposta foi SIM, responda à seguinte pergunta):
- Qual a sua impressão global sobre a ajuda que recebeu para aprender a fazer essas coisas ?
5. Ótima
 4. Predominantemente satisfatória
 3. Razoável
 2. Predominantemente insatisfatória
 1. Péssima
- NÃO** (se a resposta foi NÃO, responda à seguinte pergunta):
- Teria desejado receber esse tipo de ajuda ?
6. NÃO 7. NÃO SEI 8. SIM

*Leia atentamente todas as perguntas e demore o que for necessário antes de responder.
Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !*

Verona Service Satisfaction Scale, 1994

Por favor, leia atentamente cada uma das seguintes frases e indique a resposta que melhor descreve a sua experiência com o Serviço de **no último ano**

43. Neste último ano, tem tido sessões individuais com o seu terapeuta (com o objectivo de melhorar a compreensão que você tem do seu problema e/ou mudar algum aspecto do seu comportamento) ?

SIM (se a resposta foi SIM, responda à seguinte pergunta):

- Qual a sua impressão global sobre as sessões individuais que tem tido ?

1. Péssima
2. Predominantemente insatisfatória
3. Razoável
4. Predominantemente satisfatória
5. Ótima

NÃO (se a resposta foi NÃO, responda à seguinte pergunta):

- Teria desejado essas sessões individuais ?

6. NÃO 7. NÃO SEI 8. SIM

44. Neste último ano, esteve internado obrigatoriamente no Serviço de Psiquiatria (isto é, contra sua vontade) ?

SIM (se a resposta foi SIM, responda à seguinte pergunta):

- Qual a sua impressão global sobre o internamento obrigatório que teve ?

5. Ótima
4. Predominantemente satisfatória
3. Razoável
2. Predominantemente insatisfatória
1. Péssima

NÃO (se a resposta foi NÃO, responda à seguinte pergunta):

- Teria desejado ser internado obrigatoriamente no Serviço de Psiquiatria ?

6. NÃO 7. NÃO SEI 8. SIM

*Leia atentamente todas as perguntas e demore o que for necessário antes de responder.
Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !*

Por favor, leia atentamente cada uma das seguintes frases e indique a resposta que melhor descreve a sua experiência com o Serviço de **no último ano**

45. Neste último ano, tem tido sessões com o seu terapeuta em conjunto com os seus familiares
(com o objectivo de melhorar e/ou mudar o tipo de relacionamento no seio da família) ?

SIM (se a resposta foi SIM, responda à seguinte pergunta):

- Qual a sua impressão global sobre este tipo de sessões ?

1. Péssima
2. Predominantemente insatisfatória
3. Razoável
4. Predominantemente satisfatória
5. Óptima

NÃO (se a resposta foi NÃO, responda à seguinte pergunta):

- Teria desejado efectuar sessões deste tipo ?

6. NÃO 7. NÃO SEI 8. SIM

46. Neste último ano, tem estado alojado numa residência protegida, com pessoal de assistência ?

SIM (se a resposta foi SIM, responda à seguinte pergunta):

- Qual a sua impressão global sobre a hospitalidade recebida nessa residência ?

5. Óptima
4. Predominantemente satisfatória
3. Razoável
2. Predominantemente insatisfatória
1. Péssima

NÃO (se a resposta foi NÃO, responda à seguinte pergunta):

- Teria desejado estar alojado numa residência protegida ?

6. NÃO 7. NÃO SEI 8. SIM

*Leia atentamente todas as perguntas e demore o que for necessário antes de responder.
Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !*

Verona Service Satisfaction Scale, 1994

Por favor, leia atentamente cada uma das seguintes frases e indique a resposta que melhor descreve a sua experiência com o Serviço de **no último ano**

47. Neste último ano, tem participado em actividades recreativas organizadas pelo Serviço?

SIM

(se a resposta foi SIM, responda à seguinte pergunta):

- Qual a sua impressão global sobre as actividades recreativas em que participou ?

1. Péssima
2. Predominantemente insatisfatória
3. Razoável
4. Predominantemente satisfatória
5. Óptima

NÃO

(se a resposta foi NÃO, responda à seguinte pergunta):

- Teria desejado participar em actividades recreativas organizadas pelo Serviço ?

6. NÃO 7. NÃO SEI 8. SIM

48. Neste último ano, participou em sessões de psicoterapia de grupo (isto é, sessões de um grupo de pacientes com um ou mais terapeutas, com o objectivo de melhorar a compreensão que os pacientes têm dos seus próprios problemas, e/ou de obter alguma mudança nos seus comportamentos) ?

SIM

(se a resposta foi SIM, responda à seguinte pergunta):

- Qual a sua impressão global sobre as sessões de grupo em que participou ?

5. Óptima
4. Predominantemente satisfatória
3. Razoável
2. Predominantemente insatisfatória
1. Péssima

NÃO

(se a resposta foi NÃO, responda à seguinte pergunta):

- Teria desejado efectuar sessões de psicoterapia de grupo ?

6. NÃO 7. NÃO SEI 8. SIM

*Leia atentamente todas as perguntas e demore o que for necessário antes de responder.
Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !*

Por favor, leia atentamente cada uma das seguintes frases e indique a resposta que melhor descreve a sua experiência com o Serviço de **no último ano**

49. Neste último ano, tem estado integrado num trabalho protegido (isto é, num ambiente de trabalho tolerante para com os seus problemas, e desse modo facilitando a sua integração) ?

SIM (se a resposta foi SIM, responda à seguinte pergunta):
 - Qual a sua impressão global sobre esse trabalho protegido ?

1. Péssima
2. Predominantemente insatisfatória
3. Razoável
4. Predominantemente satisfatória
5. Ótima

NÃO (se a resposta foi NÃO, responda à seguinte pergunta):
 - Teria desejado estar integrado num trabalho protegido ?

6. NÃO 7. NÃO SEI 8. SIM

50. Neste último ano, esteve internado voluntariamente no Serviço de Psiquiatria ?

SIM (se a resposta foi SIM, responda à seguinte pergunta):
 - Qual a sua impressão global sobre o internamento voluntário que teve ?

5. Ótima
4. Predominantemente satisfatória
3. Razoável
2. Predominantemente insatisfatória
1. Péssima

NÃO (se a resposta foi NÃO, responda à seguinte pergunta):
 - Teria desejado ser internado voluntariamente no Serviço de Psiquiatria ?

6. NÃO 7. NÃO SEI 8. SIM

*Leia atentamente todas as perguntas e demore o que for necessário antes de responder.
 Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !*

Verona Service Satisfaction Scale, 1994

Por favor, leia atentamente cada uma das seguintes frases e indique a resposta que melhor descreve a sua experiência com o Serviço de **no último ano**

51. Neste último ano, recebeu ajuda em sua própria casa por parte de algum técnico(a) do Serviço (isto é, para companhia, ajuda nas tarefas domésticas, etc.) ?

SIM

(se a resposta foi SIM, responda à seguinte pergunta):

- Qual a sua impressão global sobre a ajuda em casa que recebeu ?

1. Péssima
2. Predominantemente insatisfatória
3. Razoável
4. Predominantemente satisfatória
5. Ótima

NÃO

(se a resposta foi NÃO, responda à seguinte pergunta):

- Teria desejado receber ajuda em sua casa por um técnico ?

6. NÃO 7. NÃO SEI 8. SIM

52. Neste último ano, recebeu ajuda de algum técnico do Serviço (ex.assistente social) para obter um subsídio económico ou uma pensão ?

SIM

(se a resposta foi SIM, responda à seguinte pergunta):

- Qual a sua impressão global sobre a ajuda recebida para obter um subsídio económico ou uma pensão ?

5. Ótima
4. Predominantemente satisfatória
3. Razoável
2. Predominantemente insatisfatória
1. Péssima

NÃO

(se a resposta foi NÃO, responda à seguinte pergunta):

- Teria desejado receber ajuda para obter um subsídio económico ou uma pensão?

6. NÃO 7. NÃO SEI 8. SIM

*Leia atentamente todas as perguntas e demore o que for necessário antes de responder.
Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !*

Verona Service Satisfaction Scale, 1994

Por favor, leia atentamente cada uma das seguintes frases e indique a resposta que melhor descreve a sua experiência com o Serviço de **no último ano**

53. Neste último ano, recebeu ajuda do Serviço para encontrar trabalho (um emprego não-protegido no mercado livre de trabalho) ?

- SIM** (se a resposta foi SIM, responda à seguinte pergunta):
- Qual a sua impressão global sobre a ajuda que recebeu para encontrar trabalho ?
1. Péssima
 2. Predominantemente insatisfatória
 3. Razoável
 4. Predominantemente satisfatória
 5. Óptima
- NÃO** (se a resposta foi NÃO, responda à seguinte pergunta):
- Teria desejado receber ajuda do Serviço para encontrar trabalho ?
6. NÃO 7. NÃO SEI 8. SIM

54. Neste último ano, recebeu ajuda de algum técnico do Serviço para se integrar em actividades recreativas exteriores ao Serviço de Psiquiatria (ex. actividades desportivas, culturais, etc.) ?

- SIM** (se a resposta foi SIM, responda à seguinte pergunta):
- Qual a sua impressão global sobre a ajuda recebida para se integrar em actividades recreativas exteriores ao Serviço de Psiquiatria ?
5. Óptima
 4. Predominantemente satisfatória
 3. Razoável
 2. Predominantemente insatisfatória
 1. Péssima
- NÃO** (se a resposta foi NÃO, responda à seguinte pergunta):
- Teria desejado receber ajuda para se integrar em actividades recreativas exteriores ao Serviço de Psiquiatria?
6. NÃO 7. NÃO SEI 8. SIM

*Leia atentamente todas as perguntas e demore o que for necessário antes de responder.
Lembre-se que para nós é muito importante que a sua resposta represente a sua verdadeira opinião !*

Verona Service Satisfaction Scale, 1994

POR FAVOR, ESCREVA OS SEUS COMENTÁRIOS

55. Os aspectos que mais me agradaram no contacto com este Serviço foram :

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.....

.....

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.....

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56. Os aspectos que menos me agradaram no contacto com este Serviço foram :

.....

.....

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.....

MUITO OBRIGADO PELA SUA COLABORAÇÃO

Annex 4

INFORMED CONSENT



Faculdade de Ciências Médicas
Universidade Nova de Lisboa

Formulário de Consentimento Informado

Uma investigadora do Serviço de Psiquiatria do Hospital Prof. Dr. Fernando Fonseca, que conta com a colaboração do Departamento de Saúde Mental da Faculdade de Ciências Médicas, está a realizar um estudo cujo objectivo é perceber a satisfação com os cuidados de saúde mental recebidos, das pessoas que estão a ser acompanhadas no Serviço de Psiquiatria e nas consultas de Psiquiatria na Comunidade.

O/A Senhor/a foi escolhido/a para participar neste estudo porque foi internado no Serviço de Psiquiatria.

Ser-lhe-á pedido para preencher um questionário sobre a sua Satisfação com o Serviço.

A participação no estudo é voluntária e se decidir não participar isso não afectará, de nenhum modo, os cuidados que recebe.

Todas as suas opiniões serão mantidas confidenciais.

Caso alguma questão não seja clara ou necessite mais informações, por favor pergunte à investigadora.

Para ser preenchido pelo participante

- Tive oportunidade de discutir o estudo e fazer perguntas à investigadora. Sim/Não
- Estou satisfeito com as respostas que recebi acerca do estudo. Sim/Não
- Compreendi que sou livre de não participar no estudo, e que isso não afectará o meu tratamento de nenhum modo. Sim/Não
- Estou satisfeito/a com o facto de a informação que dou ser confidencial. Sim/Não
- Concordo em participar neste estudo. Sim/Não

Nome do participante:

Assinatura:

Data: / /

Identificação da Investigadora:

Assinatura:

Data: / /



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Todas as suas opiniões serão mantidas confidenciais.

Caso alguma questão não seja clara ou necessite mais informações, por favor pergunte à investigadora.

Dra. Natasha de Oliveira

Serviço de Psiquiatria / Hospital de Dia

Contacto telefónico: 21 434 8465